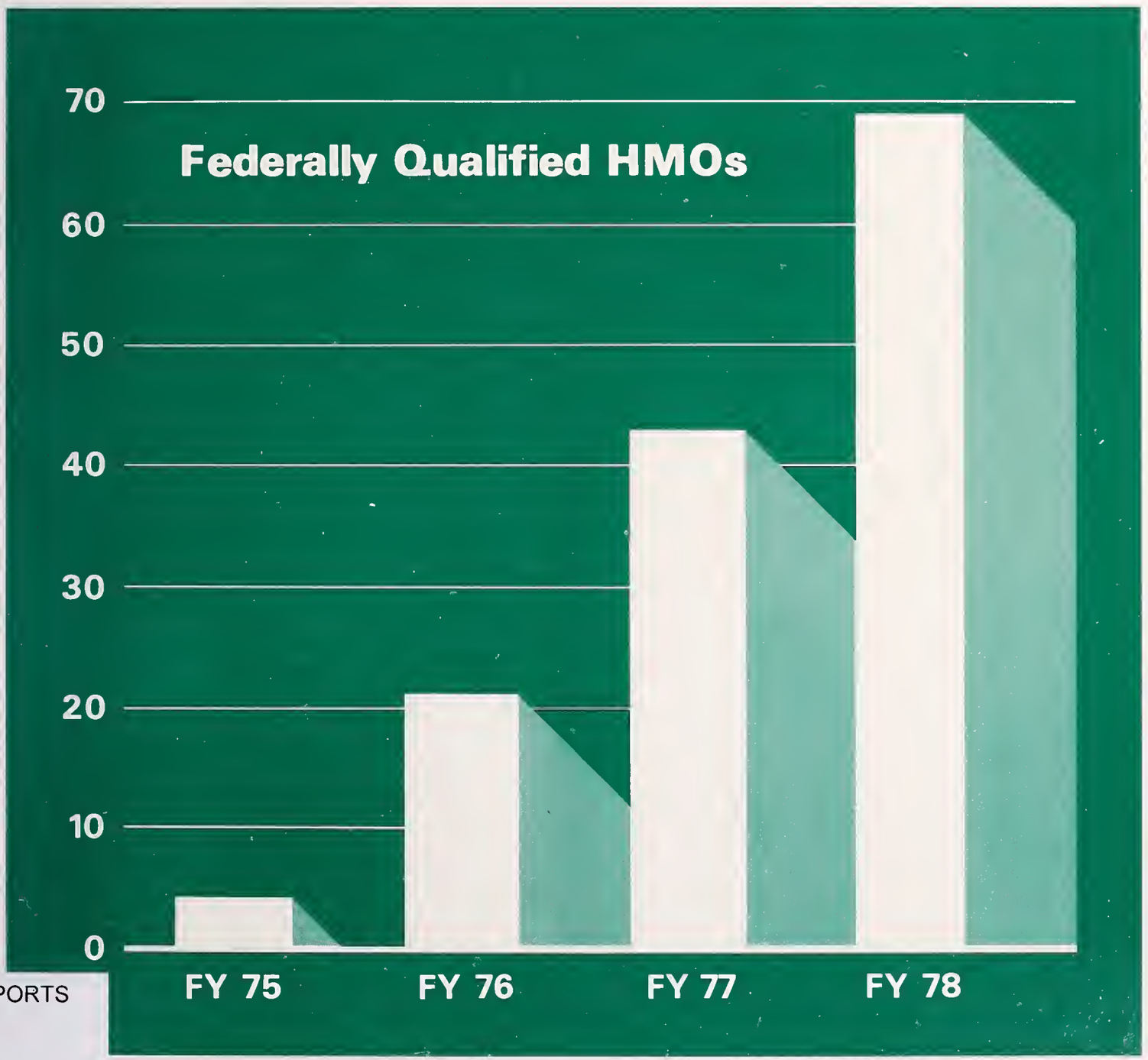
HMO

Office of Health Maintenance Organizations

4TH ANNUAL REPORT TO THE CONGRESS

SEPTEMBER 1978



U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE • Public Health Service

Office of Health Maintenance Organizations

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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Office of the Assistant Secretary for Health
Office of Health Maintenance Organizations
12420 Parklawn Drive
Rockville, Maryland 20857

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FOREWORD

I am pleased to forward this report to the Congress.

With enactment of the HMO Amendments of 1978, HMOs became part of the mainstream of health care delivery in the United States.

During the past year, health maintenance organizations, and the HMO program, made dramatic progress toward achievement of the objectives set by the Congress when it passed the original HMO legislation in 1973.

HMOs served 18 percent more people in 1978 than in 1977, an increase of 1.2 million members to a total enrollment of 7.5 million. We can point to a comparable increase in the number of new HMOs.

Today, 203 prepaid plans nationwide provide our citizens with an important alternative -- the opportunity to receive quality health care, delivered in an organized and cost-effective way. We expect approximately 240 more in the next decade with a projected enrollment of 19 million.

This report describes the continuing reform of the Federal HMO program begun in 1977. We intend to maintain the management and administrative improvements in coming years, and to take further steps to make the HMO program responsive and responsible.

This Administration is committed to the continued strong development of HMOs. The major problems in our health care delivery system are high costs, inefficiency, and uneven access. Development of new HMOs and expansion of successfully operating HMOs will serve our major national health goals of increasing access to quality health care for more of our citizens, providing a preventive approach to personal health, bringing critically needed competition into the health care system, and promoting management efficiency and cost savings.

Hale Champion
Under Secretary
Department of Health,
Education, and Welfare

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SUMMARY

SUMMARY

Highlights of HMO Activities - Fiscal Year 1978

- Congress enacted the HMO Amendments of 1978 on October 14, 1978. P.L. 95-559 was signed into law on November 1, 1978, thus closing the "demonstration chapter" of the program's history. The amendments extend the HMO program for three years and significantly increase the overall program authorization as well as the ceiling on funding for individual grants and loans. The amendments also authorize the funding of a National HMO Intern Program, the construction of ambulatory care facilities and the provision of technical assistance to grantees.

- The 1978 national HMO census of prepaid health plans reveals that overall membership in HMOs increased at an annual rate of 18 percent. As of August 30, 1978 there were 203 HMOs serving nearly 7.5 million enrollees.

    - Two-thirds of the total HMO membership is enrolled in federally qualified plans.

    - 37 States and Guam have at least one HMO, 27 States have two or more HMOs, and 6 States have ten or more HMOs.

    - 86 percent of the total membership is in prepaid group practice plans and 64 percent of all plans are prepaid group practice plans.

    - 71 percent of the total membership is in plans that have been operational for ten or more years.

    - Inpatient hospital utilization for all plans is 408 days per 1,000 members per year. Physician visits per member per year for all plans averaged 3.4 and total health plan encounters per member per year for all plans averaged 4.2.

- The Department established a new Office of Health Maintenance Organizations combining for the first time under one director the development, qualification and compliance functions of the program. Significant growth occured in virtually all major program components. For example:

    - 100 grants totaling $16,978,821 were awarded to 93 different organizations. Of this amount, 58 were feasibility (new start) grants. During fiscal year 1978, 8 expansion feasibility grants were awarded.

    - 18 loans totaling $31,100,000 and 2 loan guarantees amounting to $2,313,000 were committed. By the close of the fiscal year, the program had awarded a cumulative total of 50 loans with commitments totaling $92,546,000 and 3 loan guarantees amounting to $3,495,000.

- 26 HMOs were qualified during fiscal year 1978. This represents a 60 percent increase over fiscal year 1977's total. As of September 30, 1978, 69 HMOs were qualified. As of December 31, 1978 the number reached 81.

- A new division of HMO compliance was established, thus bolstering the program's capability to implement its regulatory responsibilities. Of special importance was the development and promulgation of a compliance strategy.

- An analysis of 28 qualified HMOs reporting for all 4 quarters of fiscal year 1978 revealed that:

  - There was an average net increase of 543 members per month.

  - Hospital inpatient days per 1,000 members per year were 449 in group model HMOs, 405 in staff model HMOs, and 481 in IPAs. This compares with a national average of 1,022 days per 1,000 persons per year.

  - Ambulatory encounters per member per year were 4.5 for group model HMOs, 4.3 for staff model HMOs, and 4.6 for IPAs. This compares with a national average of 5 physician visits per person per year.

OHMO OVERVIEW

OHMO OVERVIEW

1978 marked a year of sweeping change for the HMO program. On March 1 Secretary of Health, Education, and Welfare, Joseph A. Califano, Jr. hosted a National HMO Conference to initiate a renewed Departmental effort to promote HMO development. Secretary Califano challenged over 1,200 representatives of business and labor to examine the merits of the HMO concept and to support HMO development in communities across the nation.

The Administration's HMO Initiative reflects an underlying concern about the dramatic escalation of health care costs and the need to encourage efficient alternatives to the traditional fee-for-service practice of medicine. HMOs provide quality care and have demonstrated their effectiveness in restraining health care costs by reducing unnecessary hospital utilization. Total costs for HMO enrollees are ten to forty percent lower than those for comparable populations with traditional forms of health insurance. The Department's commitment to starting new HMOs and expanding existing HMOs reflects the desire to limit unnecessary expenditures and to ensure that significant numbers of people across the nation have the opportunity to enroll in health maintenance organizations.

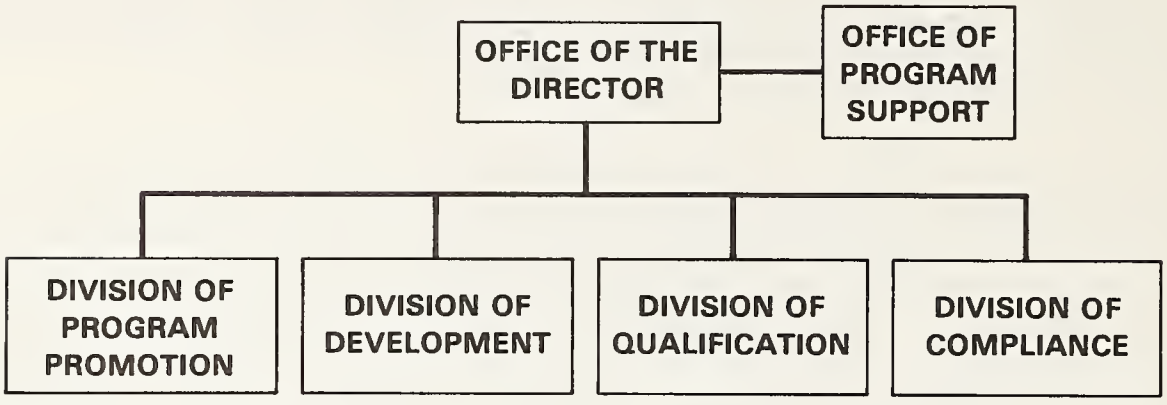
1978 Internal Organizational Changes

In the past, a number of very serious administrative problems have beset the HMO program. Program policies were fragmented and inordinate delays were caused by the organizational split between the Grant and Loan Division and the Qualification and Compliance Office.

On September 19, 1978. the Office of Health Maintenance Organizations was officially established. Program functions and staff were consolidated for the first time into one unified operation. An experienced HMO administrator was appointed as Director of the new office. At the same time the program attained new visibility and added importance because it was organizationally located in the Office of the Assistant Secretary for Health. To further strengthen management capability, the HMO office was allocated 37 additional staff and new top management was recruited to supervise five new divisions. A final organizational chart for the Office of Health Maintenance Organizations appears on page 8. As can be seen from Figure 1, the Office of Health Maintenance Organizations has been structured along functional lines. A discussion of the functions of each organizational component also appears on page 8.

Figure 1

Office of Health Maintenance Organizations



Office of the Director

- Implements the HMO program through five central office divisions and a field staff of 10 regional offices.
- Coordinates policy and regulation development.
- Develops a comprehensive strategy for national HMO development.
- Maintains liaison with interested outside organizations and groups.
- Coordinates with the Department for intergovernmental and Congressional liaison.

Office of Program Support

- Directs administrative, fiscal, and related management services.
- Implements budget formulation, presentation, and execution.
- Develops and maintains manpower management and work planning systems for the central and regional offices.
- Coordinates personnel activities.
- Manages administrative aspects of contract activities.
- Provides correspondence management.

Division of Program Promotion

- Develops strategies to increase public awareness of the HMO concept and provides assistance to federal, state, public and private agencies to identify areas for HMO development.
- Analyzes potential HMO development geographically and by sponsor.
- Coordinates promotional activities with national professional and trade organizations.
- Arranges for development, publication, and distribution of promotional, educational, and guidance materials.
- Prepares the Annual Report to Congress.

Division of Development

- Makes award recommendations and monitors grants, loans, and loan guarantees.
- Directs and coordinates grant and loan management in the central and regional offices.
- Establishes standards and procedures for HMO grant reviews and loan applications.
- Provides advice and assistance to individuals and organizations who seek to develop an HMO.

Division of Qualification

- Establishes qualification standards and determines acceptability of entities seeking to become "qualified HMOs."
- Refines review procedures to facilitate the qualification process.
- Provides guidance on interpretation of policy guidelines and regulations related to qualification.
- Provides technical assistance to HMOs.

Division of Compliance

- Assures the continuing compliance of HMOs with the statutory requirements of the HMO law.

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- Monitors employers' compliance with mandatory offering of the HMO alternative in employee health benefits plans.

- Reviews standards, procedures, and reporting requirements for monitoring HMOs that receive financial assistance.

- Establishes and updates standards and procedures for compliance monitoring of qualified HMOs.

- Reviews fiscal viability of all qualified HMOs.

Program Accomplishments in Fiscal Year 1978

HMO Promotion

In fiscal year 1978 a comprehensive market survey was conducted to measure the current extent of HMO activity and to ascertain the potential for future growth. The study provided a foundation for establishing future development and promotion strategies. In the future, the HMO program will target development in an intensified effort to create new HMOs and to stimulate enrollment in existing ones.

An effort to increase public awareness of HMOs was initiated including the development of informational materials. A monthly newsletter, distributed to approximately 5,000 addressees, provides up-to-date information on HMO activity nationally. Five HMO films are now being produced. Of these, four are tailored to specific audiences - one each for business, labor, physicians, and consumers. The fifth film, a longer version with components of each of the other films, is aimed primarily at the HMO consumer. A toll-free "hotline" Information Referral Service through which callers receive responses to inquiries about HMOs (800-638-6686) was also established.

The HMO program provided assistance to state agencies interested in promoting HMO development. Contracts were awarded to the States of Massachusetts and Pennsylvania to create model HMO offices. The State HMO Offices will actively encourage the development of new HMOs by soliciting sponsorship and support in communities. Based on experience and information generated from the project we expect that other states could replicate these model HMO offices.

The need for business and labor involvement stimulated creation of a National Industry Council. The Council, which met for the first time in January 1979, has two purposes: to foster activities which encourage the establishment of new HMOs in target communities, and to work to increase membership in existing HMOs.

A major factor in a developing HMO's acceptance within the community and ultimate success depends upon physician support. Contracts were awarded to three major national organizations to stimulate interest, support, and participation in HMOs among their membership. These organizations, the American Group Practice Association, Medical Group Management Association, and

the National Medical Association, will create a more favorable environment for HMOs by providing accurate information on HMO health care delivery to their membership and by motivating increased participation in the development of HMOs. The organizations will sponsor seminars and publish information about HMOs. In addition, the HMO program is working with the Association of American Medical Colleges to increase physician awareness of HMOs by including the HMO concept in curricula development in medical schools and in intern/residency experiences.

Lack of qualified administrative personnel historically has been a major impediment to HMO growth. In an effort to encourage universities to emphasize HMO management skills and career opportunities in their curricula, four universities were awarded funds to create HMO courses at the graduate level. The courses will provide innovations in HMO administration curricula and fill the critical need for HMO management training. It is expected that the models will be utilized in courses in other university programs in health care administration, business, and public administration.

HMO Development

During fiscal year 1978, 100 grants totaling $16,978,821 were awarded to 93 organizations. This includes 17 grants totaling $2,973,373 to qualified HMOs for expansion of their membership and/or service areas. Also during the fiscal year, 18 loans totaling $31,000,000 were made and two loan guarantees totaling $2,313,000 were signed. Of the 81 plans approved for federal qualification by December 31, 1978, 55 had received developmental grant funds.

Four major technical assessment contracts were let in the areas of Financial/Marketing, Health Care Delivery, Actuarial, and Management Information Systems. These contractors supplement staff capability and are an important resource in assuring that grantees are eligible for qualification after the developmental stage.

A major developmental activity initiated in fiscal year 1978 involved an analysis of the criteria by which grant applications are reviewed to determine if projects are fundable. Four task force groups were established to review and revise the current criteria. Once these activities are complete, objective criteria will be available against which to measure the progress of grantees and to determine their likelihood of success in developing a viable HMO. These criteria and resulting guidelines will assist grantees by providing more guidance as to what is expected of them in order to be eligible for federal qualification. This activity should result in more complete applications, a better and more timely review process, and funding decisions based on more objective criteria. An important outcome of this activity is a strengthened and effective prequalification review process. Prequalification assures the readiness of a plan to meet qualification standards prior to the submission of a qualification application.

Another very important activity initiated in fiscal year 1978, and soon to be completed, is the preparation of a written loan policy manual. This will

bring together and formalize the policies which have been used in making loans under the program. This manual will address a major criticism of the HMO program by the General Accounting Office. Availability of this manual will assure more objective and standardized loan reviews and monitoring.

In order to provide more personnel for the monitoring of loans, a training program for regional office personnel was initiated. With this training, regional staff will be able to monitor grantees and escrow agents' handling of loan funds.

HMO Qualification

During fiscal year 1978, 26 plans became federally qualified, bringing the total number of qualified HMOs to 69 on September 30, 1978. By December 31, 1978, there was a nationwide total of 81 plans approved for federal qualification.

Since the last annual report, the program initiated a number of activities to accelerate the qualification process. This process was historically plagued by procedural problems and delays in the conduct of qualification reviews. The Qualification Division instituted a target of 120 days for completing review of qualification applications. As of September 30, 1978, the Division had reduced to three the number of applications on hand and complete for more than 120 days, where the applicant had not requested a deferral.

A newly implemented monitoring system also should prove beneficial in several ways. Applicant HMOs will be able to plan their activities and fiscal positions more strategically with the 120 day timeline as a known factor. This monitoring system will readily indicate any divergence from projected target dates.

A major program accomplishment is the newly revised qualification application form. Experts in the field estimate that an applicant's time for completing the streamlined and simplified application will be cut by as much as 50 percent. In streamlining the application, the program sought to cut red tape significantly and at the same time ensure that the required information is adequate for the qualification determination and that no vital information was either eliminated or ignored. In addition, the new form will assist in speeding up internal review. The form is now geared toward a tabular rather than narrative approach to provide the needed information. Applicants still can include special explanatory information that may be helpful in determining if the plan is eligible for qualification. To complement the new application form and improved process, a series of planned seminars will familiarize potential qualification applicants with the requirements, the process, and the availability of assistance through the Office of Health Maintenance Organizations.

To further expedite the process, the program has initiated a project to ensure that, to the extent possible, the same specialists used in the prequalification review and site visit continue on through the qualification process. The obvious advantages relate to continuity and familiarity with the project since these factors play such an important role in minimizing processing time.

HMO Compliance

With the increase in the number of qualified plans, the program established for the first time a separate and distinct compliance division and received authority to hire new staff in order to strengthen this function.

During fiscal year 1978, two major priorities were the development of a comprehensive compliance plan and a quality assurance strategy. On June 27, 1978 the Department published in the Federal Register the proposed compliance plan and notice of a public hearing to discuss (1) the implementation of the Department's responsibility for assuring Health Maintenance Organizations' compliance with applicable laws and regulations, and (2) the delineation of requirements for quality assurance systems to be implemented by HMOs.

A proposed quality assurance strategy also was developed. The program relied on the advice and recommendations of an outside task force of expert physicians. Interested organizations and others knowledgeable about health care delivery also provided input. The quality assurance strategy will constitute the basic policy in the regulation of the quality of services provided by HMOs. It consists of two main components. The first is an internal program, managed by the HMO, for assuring the quality of care. The second is an independent assessment of the quality of services and the effectiveness and appropriateness of the internal quality assurance program in individual HMOs. This external assessment will be conducted by a private organization not associated with the HMO.

Another major project initiated in fiscal year 1978 was the design of an automated "HMO Early Warning System." The primary purpose of the system is to strengthen the evaluation and monitoring capabilities for the Compliance and Development Divisions. The system aids in analyzing financial and utilization data submitted by qualified HMOs and plans receiving federal grants or loans. Data are compared with the experiences of similar types of HMOs, the industry in general, and the experience predicted by the HMO itself when it applied for federal assistance or qualification. Measurable parameters will be incorporated into the system to provide further indications of operational success or difficulties at the HMO. By using this system, the program will be in a better position to suggest early corrective action to HMO management, provide technical assistance in those areas where it is most needed, and monitor subsequent HMO performance against recommended corrective action.

New National Data Reporting Requirements will be used in routine monitoring of qualified HMOs and in assessing the impact of significant variance of actual utilization or incurred expenses from approved budgets. Compliance officers also review proposed changes in benefit agreements, provider contracts, organizational modifications, revised financial plans, and expansion of service areas for their conformance to regulatory requirements. When there is sufficient reason to believe qualified HMOs are not meeting the statutory and regulatory specifications, a notice of review is issued. The results of this assessment could lead to a notice of noncompliance and eventually, if necessary, to revocation of qualification.

Regulations are being developed to implement the requirements of Section 1318 of the HMO Act. These regulations will require full financial disclosure by the HMO and parties of interest in order to preclude inappropriate financial self-dealing. Concern about identifying and preventing inappropriate financial self-dealing by HMOs is shared by other federal and State regulatory agencies. The Division of Compliance is working with the Medicare and Medicaid agencies in the development of their regulations to implement Sections 1124 and 1902 of the Social Security Act.

In addition to the above, the employer compliance activities have been strengthened. A number of common problems and concerns with respect to the dual choice mandate have been expressed by employers and HMOs alike. The program is working to develop easily understandable regulations, specific procedures for handling employer complaints, and procedures for engaging in employer/HMO negotiations if necessary. This effort will continue throughout the next fiscal year.

CONCLUSION

Several projects undertaken by the program over the past year impact on the administration and management of all five divisions. One of the most useful tools in grasping management problems and correcting identified inadequacies has been implementation of the Department's Major Initiatives Tracking System (MITS) for the HMO program. For the first time, specific program objectives are being measured by defined standards; performance problems can now be cited and corrected early. Implementation of the MITS has improved program efficiency.

Another major effort not previously referenced in this Annual Report involves the expedited development and issuance of HMO regulations. During fiscal year 1978, 5 sets of regulations were published in the Federal Register by the Department. One set was finalized, 2 sets were published as a notice of proposed rulemaking for public comment, and 2 other sets were issued as interim final regulations. In fiscal year 1979, we anticipate publication of 6 sets of regulations which are intended to fully implement the 1978 Amendments. Development of some of these regulations involve the cooperative efforts of the Bureau of Health Planning or the Health Care Financing Administration.

Critical policy issues were grappled with and for the first time, attempts are being made to bring these to resolution. Development of third party policies, a community rating paper, quality assurance, and policy issues such as open enrollment waiver criteria, risk sharing, copayments, and the status of HMOs under certificate of need and Employee Retirement Income Security Act are now being addressed.

Finally, and most significant in the longer term, the program has set out to develop and articulate a policy for HMO development over the next several years. The approach involves targeting of our resources on those areas of the country ripe for HMO development and most likely to yield the highest cost savings for federal expenditures.

The HMO growth and development initiative is based on the underlying assumption that HMOs are an attractive alternative to traditional practice of fee-for-service medicine. The beneficial efforts of HMOs include improved access to the health care system for consumers, emphasis on early detection of disease, quality of care, lower health care costs and increased competition in the health market place. The overall goal of the Department is to keep the HMO movement "takeoff" nationwide in order to bring the advantageous impact of HMOs to bear on the health care system.

The HMO development strategy will seek to attain the highest possible community cost savings and at the same time accomplish high HMO enrollment and optimum growth of HMOs across the country. Implementation of this targeted approach will enable us to more effectively plan and manage program resources. The program is also examining the best ways of stimulating greater private investment in HMO development and the federal policies which need to be designed to foster this growth.

In summary, during fiscal year 1978, significant administrative and managerial reforms were initiated to correct past deficiencies, strengthen program operations, and increase the efficiency and improve the responsiveness of the program to its grantees and others outside the Department. Many accomplishments can be cited. Other improvements are well on track. Still others have begun since the close of the fiscal year on September 30 and are not described in this report.

1978 Amendments

Enactment of P.L. 95-559, signed into law by President Carter on November 1, 1978, signals Congressional acceptance of the end of the "HMO demonstration" and the beginning of a new chapter in the history of HMO development. The House stated "By extending the authorization for the HMO program the proposed legislation changes the federal role with respect to the program from one which was initially conceived as initial support of a demonstration program to one which provides support for HMO development on a continuing basis. HMOs are now viewed as a positive reform of the health care delivery system which provide an alternative to the more traditional fee-for-service practice of medicine." Congress gave recognition to Secretary Califano and Under Secretary Champion's efforts to improve the management of the program through "reorganization and aggressive measures to improve the program's productivity."

The 1978 amendments to Title XIII of the Public Health Service Act provide for a three year extension of the federal HMO development program through fiscal year 1981, correction of certain deficiencies in the existing law, and addition of several new authorities.

In addition to stipulating authorization levels of $31 million for fiscal year 1979, $65 million for 1980, and $68 million for 1981, the major provisions include requirements directing the program to:

- Increase the maximum limits on grant and loan authorities. Effective October 1, 1979, initial development grants can be awarded up to a maximum of $2 million. Up to $2 million annually and $4 million in total loan and loan guarantees will now be available to HMOs to defray initial deficits of the costs of operation. The amendments also specify that initial development grants, contracts, and loan guarantees can be used for expansion of services.

  Allow up to $2.5 million in loan and loan guarantees to be used for the acquisition or construction of ambulatory care facilities and for the acquisition of equipment for these facilities.

- Provide technical assistance to both preoperational and qualified HMOs.

- Require HMOs to provide for financial disclosure which allows the Secretary to determine if the HMO is fiscally sound and prudently managed. If an organization is related to the HMO by common ownership or control, the Secretary may require the filing of a consolidated financial statement. Penalties are provided for instances of fraud and abuse.

- Establish a National Health Maintenance Organizations Intern Program to provide management training to current and potential HMO administrators and medical directors to improve the quality of management

required for successful operation of an HMO.

- Require employers who provide payroll deductions as a means of paying employees' contributions for health benefits or who provide health benefits for which an employee contribution is not required, to arrange for payroll deductions for HMO membership premiums.

- Eliminate the community rating requirements for full-time college students.

- Allow HMOs to combine group, staff and individual practice association models of delivery.

- Eliminate the requirement that applicants for feasibility grants demonstrate financial inability to complete the project without federal support.

- Allow public HMOs to have an advisory board with delegated policy-making authority for the organization, rather than requiring HMOs to meet the one-third consumer requirement in section 1306(c)(6) of the law.

- Remove the prohibition in section 1313 regarding the source of funding for migrant health projects and community health centers who are planning for or providing health services on a prepaid basis.

- Clarify provisions for the following areas: responsibility of an HMO to provide services in the event of a national disaster, riot, or other events not within the control of an HMO; contracting for physician services; responsibility for extending coverage for unusual or infrequently provided services; responsibility to provide reimbursement under worker's compensation laws.

In addition to the above amendments to Title XIII, the new legislation contains the following:

- Amendment of section 1122 of the Social Security Act to provide that establishment of an HMO will not be covered under the review authority for capital expenditures of the State Health Planning Agencies and development of outpatient facilities and services will be covered only to the extent that a health care facility would be covered for the same activity.

- Protection against conflict of interest of State and local employees who are responsible for the expenditure of substantial amounts of Medicaid funds.

- A requirement that the Comptroller General evaluate and report to Congress by May 1, 1979 on the management and adequacy of funding of the grant and loan programs.

GRANT AND LOAN PROGRAM

GRANT AND LOAN PROGRAM

The HMO Act authorizes three types of grants designed to progress in sequence: (1) Feasibility grants to survey the legal situation, the market potential, the physician availability and attitude, the facility needs, and the financial considerations; (2) Planning grants to mobilize the established resources and activate the work plan; and (3) Initial Development grants to physically complete all activities necessary to place the HMO in operation. Grantees tend to require an average of 12 months for feasibility and 12 months for planning to complete the necessary tasks. Initial development requires from 12 to 24 months to complete. As funded projects progress through the developmental stages, they are usually accepted for advancement on an individual basis if they demonstrate that they have completed the required activities at the previous stage and have a realistic plan to become a viable HMO.

During fiscal year 1978, feasibility projects were limited to a maximum of $75,000 and planning grants had a maximum of $200,000. The Act authorized two feasibility and two planning grants to organizations, where required, to complete the tasks. All projects are limited to a total of $1,000,000 in initial development grant funds, except for certain expansion activities. The 1978 Amendments to the Act modify the initial development authorizations: during fiscal year 1979 all initial development grantees are limited to $1,000,000 and in fiscal year 1980 the maximum is increased to $2,000,000.

Grantees who receive less than the maximum allowable grant award may apply for a supplemental grant to complete the project. For example, a feasibility project funded for $60,000 could receive up to $15,000 in supplements, where necessary. Due to the fact that projects progress on an individual basis, some projects receive two or more awards during the same fiscal year. The multiple awards could be the same type, such as two planning grants, or for progressive levels of development, such as one feasibility grant and one planning grant. As a result, the number of grants awarded does not equate to the number of organizations supported.

Since 1975, 390 grants totaling $74,558,790 have been awarded under Title XIII of the Public Health Service Act. One or more development grants were made to 227 plans during the four year period. Fourteen percent of the funds was awarded for feasibility studies, eighteen percent for planning, and sixty-eight percent for initial development.

Table 1 displays the aggregate funding pattern of feasibility, planning, and initial development grants from fiscal year 1975 through fiscal year 1978. As the table indicates, a significant number of projects were funded in fiscal year 1975 (157). However, because of budget constraints during fiscal year 1976 and fiscal year 1977, there was a sharp decline (to 64 and 42 respectively), but this was then followed by an increase in projects funded to 114 in fiscal year 1978. Of significance is the fact that only 5 feasibility grants were awarded in fiscal year 1977, as compared to 66 in fiscal year 1978.

TABLE 1: SUMMARY OF GRANT MONIES AWARDED UNDER TITLE XIII OF THE PHS ACT
FISCAL YEARS 1975 - 1978

	F.Y. 1975	F.Y. 1976 [1]	F.Y. 1977	F.Y. 1978	F.Y. 1975 - 1978
TYPE OF GRANT					
Feasibility					
Number of Grants Awarded	108	11	5	66	190
Total Dollars Awarded [2]	$ 5,196,281	$ 509,370	$ 208,686	$ 4,543,193	$10,457,530
Planning					
Number of Grants Awarded	31	41	15	13	100
Total Dollars Awarded [2]	$ 3,758,745	$ 5,080,602	$ 2,223,133	$ 2,068,433	$13,130,913
Initial Development					
Number of Grants Awarded	33	20	26	21	100
Total Dollars Awarded [2]	$13,507,274	$12,580,368	$14,515,510	$10,367,195	$50,970,347
ALL GRANTS					
Number of Projects Funded	157 [3]	64 [4]	42 [5]	114 [6]	227 [7]
Number of Grants Awarded	172	72	46	100	390
Number of Supplemental Grants	7	25	25	41	98
Total Dollars Awarded	$22,462,300	$18,170,340	$16,947,329	$16,978,821	$74,558,790

1/ Fifteen month fiscal year.

2/ All dollar amounts include supplemental grant funds even though the number of grants excludes supplemental grants.

Footnotes to Table 1 (Continued)

3/ In FY 1975 fifteen of the 157 grantees received multiple awards (1 plan received 2 planning grants, 2 plans received 2 I.D. grants, 3 plans received both a feasibility and planning grant, 7 plans received both a planning and I.D. grant, 2 plans received both a feasibility and I.D. grant). In addition, 7 supplemental grants were made to plans whose existing grants expired during the year (2 planning, 5 initial development).

4/ In FY 1976, eight of the 64 grantees received multiple awards (1 plan received 2 I.D. grants, 4 plans received both a feasibility and a planning grant, 3 plans received both a planning and I.D. grant). In addition, 25 supplemental grants were made to plans whose existing grants expired during the year (3 feasibility, 2 planning, and 20 initial development).

5/ In FY 1977 four of the 42 grantees received multiple awards (3 plans received both a planning and I.D. grant, 1 plan received both a feasibility and an I.D. grant). In addition, 25 supplemental grants were made to plans whose existing grants expired during the year (1 feasibility, 11 planning, and 13 initial development).

6/ In FY 1978, 114 organizations received 141 grants including supplemental grants. Twenty of the 114 grantees received supplemental grants only. The remaining 94 organizations received 2 types of grants. (2 plans received both a feasibility and a planning grant, 2 plans received both a planning and I.D. grant, 2 plans received both a feasibility and an I.D. grant.) In addition, 41 supplemental grants were awarded to plans whose existing grants expired during the year (2 feasibility, 15 planning, and 24 initial development).

7/ This number counts each organization once, irrespective of the number of grants it received.

During fiscal year 1978, the HMO program awarded 100 separate grants to 93 plans. Of the $16,978,821 in grant monies, twenty-seven percent was awarded for feasibility studies, twelve percent for planning, and sixty-one percent for initial development. Table 2 shows a distribution of the funds awarded by type of grant.

TABLE 2: FUNDING BY TYPE OF GRANT - FISCAL YEAR 1978

	Number of Grants Awarded*		
	Development	Expansion**	Total Amount Awarded
Total Grants	83	17	$16,978,821
Feasibility	58	8	$ 4,543,193
Planning	9	4	$ 2,068,433
Initial Development	16	5	$10,367,195

* Excluding supplemental grants.

** Grants totaling $2,973,737 were awarded to qualified HMOs for expansion of their membership and/or service areas.

As Table 2 indicates, 17 qualified HMOs received expansion grants in fiscal year 1978. These grants are helping qualified HMOs plan for expansion of their service areas and total membership. The funds provide these HMOs the necessary resources to accelerate HMO availability to citizens in local communities. Some HMOs are only starting such expansion activities (i.e., feasibility and planning grants) while others are in the final stages of developing their expanded capabilities (i.e., initial development).

Approximately ten percent of the grant funds went to projects planning to serve non-metropolitan areas. Projects proposing to deliver care to medically underserved areas, some of which are also non-metropolitan areas, also received approximately ten percent of the grant funds. More than half of this money was awarded to consumer-sponsored organizations.

Table 3 displays the sponsorship of feasibility grants from fiscal year 1975 through fiscal year 1978. As the table indicates, the consumer groups accounted for about forty percent of grants in fiscal year 1975 and fiscal year 1978. However, physician groups increased their overall percentage of grants from about twenty-five percent in fiscal year 1975 to about thirty-five percent in fiscal year 1978. Hospitals decreased from about eighteen percent to about five percent.

TABLE 3: SPONSORS OF PROJECTS RECEIVING FEASIBILITY GRANTS
FISCAL YEARS 1975 - 1978

Sponsor of Feasibility Projects	F.Y. 1975	F.Y. 1976	F.Y. 1977	F.Y. 1978
Total Feasibility Projects	108	11	5	66
Consumer	48	5	3	26
Public	3	0	0	0
Hospital	22	0	0	3
Physician	27	5	2	23
Private	6	1	0	13
Medical School	2	0	0	1

Also, on the following pages Table 4 provides a complete listing of organizations funded in fiscal year 1978.

Since 1975, 53 HMOs have received loan assistance under Title XIII of the Public Health Service Act. Fifty of these organizations have received direct loan commitments totaling $92,546,000. Three HMOs have received loan guarantees totaling $3,495,000. During fiscal year 1978, 18 loans totaling $31,100,000 were made and two loan guarantees totaling $2,313,000 were signed.

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TABLE 4: HMO GRANT AND LOAN PROFILES - FISCAL YEAR 1978

KEY: ID-Initial Development
F-Feasibility
P-Planning
Grp-Group Practice
IPA-Individual Practice Association
Pri-Private
Phy-Physician
Hosp-Hospital
Con-Consumer
(s)-Supplemental
(x)-Expansion
LG -Loan Guarantee

	TYPE OF GRANT	MODEL	SPONSOR	NON-METRO	MUA	FY 78 GRANT FUNDING	LOANS MADE IN FY 78	DATE OF LOAN
Region I								
Connecticut								
. Conn. Family Hlth Care Bridgeport, Connecticut	F(x)	Grp	Con	--	--	75,000	--	--
. Greater Bridgeport Med. Health Fdn. Bridgeport, Connecticut	F	IPA	Phy	--	--	75,000	--	--
. Hlth Mgmt. Institute Greenwich, Connecticut	F	Grp	Pri	--	--	54,280	--	--
. New Haven Cty Fdn. for Medical Care Woodbridge, Connecticut	F	IPA	Phy	--	--	60,632	--	--
. North Central Conn. HMO Windsor, Connecticut	P(s) ID	Grp	Public	--	--	70,000 844,782	--	--
Massachusetts								
. Athol Memorial Hosp. Athol, Mass.	F	IPA	Hosp	--	--	71,581	--	--
. Fallon Community Hlth Plan Worcester, Mass.	ID(s)	Grp	Phy	--	--	70,587	--	--
. Healthway Med. Plan Brockton, Mass.	F	Grp	Pri	--	--	67,000	--	--
. Tufts University Boston, Mass.	F	Grp	Med School	--	--	75,000	--	--
New Hampshire								
. Matthew Thornton Hlth Plan Nashua, New Hampshire	None	Grp	Phy	--	--	--	859,000	9/21/78
. Seacoast Comp. Hlth Systems Portsmouth, New Hampshire	F	IPA	Con	X	--	71,083	--	--

TABLE 4: HMO GRANT AND LOAN PROFILES - FISCAL YEAR 1978 (Cont'd)

	TYPE OF GRANT	MODEL	SPONSOR	NON-METRO	MUA	FY 78 GRANT FUNDING	LOANS MADE IN FY 78	DATE OF LOAN
Region I (Cont'd)								
Rhode Island								
. RIGHA Providence	ID(x)	Grp	Con	--	--	492,255	500,000	1/18/78
Region II								
New Jersey								
. Crossroads Hlth Plan East Orange, New Jersey	ID	IPA	Phy	--	--	86,800	2,500,000	4/12/78
. Group Hlth Plan of N.J. Guttenberg, N.J.	F(x) (s) (s)	Grp	Con	--	--	63,145 3,000 8,833	--	--
. Health Care Plan of N.J. Morrestown, N.J.	F(x) P(x)	Grp	Con	--	--	66,590 75,000	--	--
. Middlesex and Union Cty Med. Soc. East Brunswick, N.J.	F	IPA	Phy	--	--	72,914	--	--
New York								
. Capital Area Comm. Hlth Plan Albany, N.Y.	P(x) ID(x)	Grp	Con	--	--	190,469 100,000	--	--
. Community Hlth Plan of Suffolk Stony Brook, N.Y.	ID(s)	Grp	Con	--	--	9,774	--	--
. Community Services Res. Fdn. Hempstead, N.Y.	F	Grp	Con	--	--	64,646	--	--
. HealthCare Plan, Inc. Buffalo, N.Y.	ID(s)	Grp	Con	--	X	9,342	2,500,000	9/8/78
. Health Services Med. Corp. Baldwinsville, N.Y.	F	Grp	Con	--	--	74,950	--	--
. Rochester Area HMO Rochester, N.Y.	ID	IPA	Con	--	--	367,441	--	--

TABLE 4: HMO GRANT AND LOAN PROFILES - FISCAL YEAR 1978 (Cont'd)

	TYPE OF GRANT	MODEL	SPONSOR	NON-METRO	MUA	FY 78 GRANT FUNDING	LOANS MADE IN FY 78	DATE OF LOAN
New York (Cont'd)								
. Manhattan Hlth Plan, Inc. New York, N.Y.	None	Grp	Con	--	--	--	2,500,000	12/2/77
. Western N.Y. Grp. Hlth Plan Getzville, N.Y.	P	IPA	Con	--	--	189,953	--	--
Region III								
Maryland								
. Health Care Plan of Ann Arundel Annapolis, Md.	F	IPA	Phy	--	--	70,000	--	--
. Health Plus, Inc. Hyattsville, Md.	ID(s) (s)	IPA	Phy	--	--	163,124 75,000	--	--
. Metro Baltimore Hlth Care Baltimore, Md.	ID(s)	Grp	Con	--	--	237,564	2,500,000	4/5/78
. St. Charles Hlth Services St. Charles, Md.	F	IPA	Pri	--	--	68,400	--	--
. United Way of the Nat'l. Capital Area Rockville, Md.	F	IPA	Con	--	--	72,146	--	--
Pennsylvania								
. Cannonsburg General Hospital Cannonsburg, Pa.	F	IPA	Hosp	--	--	72,377	--	--
. Forbes Health Maintenance Plan Pittsburgh, Pa.	ID	IPA	Hosp	--	--	314,876	--	--

TABLE 4: HMO GRANT AND LOAN PROFILES - FISCAL YEAR 1978 (Cont'd)

	TYPE OF GRANT	MODEL	SPONSOR	NON-METRO	MUA	FY 78 GRANT FUNDING	LOANS MADE IN FY 78	DATE OF LOAN
Pennsylvania (Cont'd)								
. Greater Del. Valley Health Care Fdn. Ardmore, Pa.	ID(s) (s)	IPA	Con	--	--	250,615 220,412	--	--
. Health Services Plan Philadelphia, Pa.	ID(x)	Grp	Phy	--	--	227,610	--	--
. Penn Grp Hlth Plan Pittsburgh, Pa.	ID(x)	Grp	Phy	--	--	896,342	1,050,000	2/10/78
Virginia								
. Piedmont Medical Plan Earlysville, Va.	F	IPA	Con	X	--	68,000	--	--
West Virginia								
. Country Roads Hlth Plan Beckley, W. Va.	ID	IPA	Con	X	X	432,499	--	--
. No. Central W.Va. Plan Fairmont, W. Va.	F	Grp	Con	X	--	75,000	--	--
. Ohio Cty Fdn. for Med. Care Wheeling, W. Va.	F P	IPA	Phy	--	--	39,000 33,310	--	--
Region IV								
Alabama								
. Jefferson Hlth Fdn. Birmingham, Ala.	F	Grp	Pri	--	--	75,000	--	--
Florida								
. Av-Med Health Plan Miami, Fla.	None	IPA	Phy	--	--	--	[LG] 1,100,000	10/14/78
. Broward Teachers Union Ft. Lauderdale, Fla.	F	Grp	Con	--	--	75,000	--	--
. Capital Grp Hlth Services of Florida Tallahassee, Fla.	F	Grp	Pri	--	X	70,000	--	--

TABLE 4: HMO GRANT AND LOAN PROFILES - FISCAL YEAR 1978 (Cont'd)

	TYPE OF GRANT	MODEL	SPONSOR	NON-METRO	MUA	FY 78 GRANT FUNDING	LOANS MADE IN FY 78	DATE OF LOAN
Florida (Cont'd)								
. Florida Health Care Daytona Beach, Fla.	None	Grp	Phy	--	--	--	442,000	3/16/78
. Pre-Paid Health Plan Clearwater, Fla.	None	Grp	Con	--	--	--	2,500,000	9/7/78
. South Florida Grp Hlth Plan Miami, Fla.	F	IPA	Con	--	X	75,000	--	--
. Spanish American South Miami, Fla.	F	Grp	Con	--	--	75,000	--	--
Georgia								
. Atlanta Med. Res. Fdn. Atlanta, Ga.	F	IPA	Pri	--	--	75,000	--	--
. Health Care, Inc. Decatur, Ga.	P(s) ID	Grp	Con	--	--	5,600 150,000	--	--
. Metro Atlanta Hlth Plan Atlanta, Ga.	P P(s)	IPA	Phy	--	--	175,000 75,000	--	--
Kentucky								
. Clinic Health Care Madisonville, Kentucky	F	Grp	Pri	X	X	74,985	--	--
. Health Care of Louisville Louisville, Ky.	ID(x)	Grp	Con	--	X	112,091	1,025,000	1/9/78
. Hunter Fdn. for Hlth Lexington, Ky.	F	Grp	Con	--	--	73,304	--	--
. Laurel River HMO Plan London, Ky.	P(s)	Grp	Con	X	X	75,000	--	--
. Mountain Trails Middlesboro, Ky.	F	Grp	Con	X	X	65,615	--	--
. Pennyrille Elkton, Ky.	F	IPA	Phy	X	X	74,568	--	--

TABLE 4: HMO GRANT AND LOAN PROFILES - FISCAL YEAR 1978 (Cont'd)

	TYPE OF GRANT	MODEL	SPONSOR	NON-METRO	MUA	FY 78 GRANT FUNDING	LOANS MADE IN FY 78	DATE OF LOAN
Region IV (Cont'd)								
Mississippi								
. Christian Senior Housing Jackson, Mississippi	F	Grp	Con	--	X	65,000	--	--
South Carolina								
. Piedmont Health Care Corp Greenville, So. Car.	F(x)	Grp	Pri	--	--	70,860	--	--
Tennessee								
. Christian Senior Housing Nashville, Tenn.	F	Grp	Con	--	--	70,000	--	--
. East Tennessee Hlth Care Knoxville, Tenn.	F	Grp	Con	--	--	75,000	--	--
. HMO of Tennessee Memphis, Tenn.	P(s) P	IPA	Con	--	X	75,000 50,000	--	--
Region V								
Illinois								
. Anchor Org. for HMO Chicago, Ill.	ID(s)	Grp	Hosp	--	--	36,030	--	--
. North Communities Hlth Plan Evanston, Ill.	F(x)	Grp	Con	--	--	75,000	1,250,000	4/6/78
. No. Ill. Fdn. for Med. Care Rockford, Ill.	F	IPA	Phy	--	--	65,633	--	--
. PreCare, Inc. East St. Louis, Ill.	F	IPA	Phy	--	--	72,000	--	--
. Southside Comm. Hlth Plan Chicago, Ill.	P(s)	Grp	Phy	--	X	66,021	--	--

TABLE 4: HMO GRANT AND LOAN PROFILES - FISCAL YEAR 1978 (Cont'd)

	TYPE OF GRANT	MODEL	SPONSOR	NON-METRO	MUA	FY 78 GRANT FUNDING	LOANS MADE IN FY 78	DATE OF LOAN
Region V (Cont'd)								
Michigan								
. Genesee Hlth Care, Inc. Flint, Mich.	P	IPA	Phy	--	--	60,000	--	--
. Group Hlth Services of Michigan Saginaw, Mich.	P ID	Grp	Con	--	--	67,500 50,000	--	--
. Health Central, Inc. Lansing, Mich.	ID(s)	Grp	Con	--	--	90,000	2,500,000	12/16/77
Minnesota								
. Ramsey Health Plan St. Paul, Minn.	F	Grp	Phy	--	--	44,543	--	--
. SHARE St. Paul, Minn.	F(x)	Grp	Phy	--	--	75,000	--	--
Ohio								
. Akron Hlth Fdn., Inc. Akron, Ohio	P	IPA	Phy	--	--	182,115	--	--
. Buckeye Hlth Plan Cleveland, Ohio	ID ID(s)	IPA	Phy.	--	X	60,000 303,189	--	--
. Community Hlth Plan of W. Central Ohio Troy, Ohio	ID(s)	IPA	Hosp	X	--	50,000	--	--
. Medical Fdn. of Bellaire Bellaire, Ohio	F	Grp	Con	--	--	60,087	--	--
. Toledo Hlth Plan, Inc. Toledo, Ohio	ID(s) ID	Grp	Con	--	--	828,400 71,600	--	--
Wisconsin								
. Family Hlth Plan Milwaukee, Wisc.	ID ID(s)	Grp	Con	--	--	913,083 86,917	--	--

TABLE 4: HMO GRANT AND LOAN PROFILES - FISCAL YEAR 1978 (Cont'd)

	TYPE OF GRANT	MODEL	SPONSOR	NON-METRO	MUA	FY 78 GRANT FUNDING	LOANS MADE IN FY 78	DATE OF LOAN
Region VI								
Louisiana								
. Coordinated Hlth Plan of Greater New Orleans New Orleans, La.	F	Grp	Pri	--	--	75,000	--	--
. Coordinated Hlth Plan of Shreveport Shreveport, La.	F	Grp	Pri	--	--	75,000	--	--
. HMO of Baton Rouge Baton Rouge, La.	ID(s)	Grp	Phy	--	--	88,622	2,500,000	4/3/78
Texas								
. Group Health of El Paso El Paso, Texas	ID(s)	Grp	Con	--	--	101,964	1,145,000	7/25/78
. Health Prepaid Services of Dallas Dallas, Texas	P(s) P(s) P(s)	Grp	Con	--	--	32,122 12,559 30,003	--	--
. Metro Care Arlington, Texas	ID ID(s)	IPA	Pri	--	--	58,306 139,397	--	--
. Scott and White Clinic Temple, Texas	F	Grp	Pri	X	--	74,959	--	--
. S.W. Medical Plan San Antonio, Texas	ID(s)	Grp	Hosp	--	--	205,952	--	--
. Tarrant HMO Ft. Worth, Texas	P P(s)	IPA	Pri	--	--	44,738 77,660	--	--
. Trans Pecos Fdn. for Medical Care El Paso, Texas	F	IPA	Phy	--	--	68,806	--	--

TABLE 4: HMO GRANT AND LOAN PROFILES - FISCAL YEAR 1978 (Cont'd)

	TYPE OF GRANT	MODEL	SPONSOR	NON-METRO	MUA	FY 78 GRANT FUNDING	LOANS MADE IN FY 78	DATE OF LOAN
Region VII								
Kansas								
. Bethel Clinic Newton, Kansas	F	Grp	Phy	X	--	75,000	--	--
. Community Hlth Care Assn. Wichita, Kansas	F	IPA	Con	--	--	75,000	--	--
Missouri								
. Resqu, Inc. Springfield, Missouri	F	IPA	Con	--	--	67,320	--	--
. St. Louis Employ. ACWU Benefit Plan St. Louis, Missouri	F	IPA	Con	--	--	75,000	--	--
Nebraska								
. Family Hlth Care, Inc. Omaha, Nebraska	F	Grp	Con	--	--	42,455	--	--
. Health Central Lincoln, Nebraska	ID ID(s)	Grp	Con	--	--	500,000 500,000	--	--
Region VIII								
Colorado								
. Choice Care Hlth Svcs. Ft. Collins, Colorado	P(x)	IPA	Phy	X	--	68,521	--	--
. Colorado Hlth Care Svcs. Denver, Colorado	F(x) ID(x)	IPA	Phy	--	--	19,522 170,201	--	--
. Peak Hlth Study Group Colorado Springs, Co.	F	Grp	Phy	--	--	69,764	--	--
. Rocky Mt. HMO Grand Junction, Co.	F(x)	IPA	Phy	X	X	14,706	--	--
. San Luis Valley HMO Alamosa, Co.	ID(s)	IPA	Con	X	X	77,592	--	--
. So. Denver Hlth Maint. Services Englewood, Co.	F	IPA	Hosp	--	--	70,000	--	--

TABLE 4: HMO GRANT AND LOAN PROFILES - FISCAL YEAR 1978 (Cont'd)

	TYPE OF GRANT	MODEL	SPONSOR	NON-METRO	MUA	FY 78 GRANT FUNDING	LOANS MADE IN FY 78	DATE OF LOAN
Region VIII (Cont'd)								
Montana								
. S. E. Montana Hlth Plan Miles City, Montana	P(s)	IPA	Phy	X	X	6,536	--	--
North Dakota								
. Hub of America HMO Planning Council Rugby, No. Dakota	F	Grp	Phy	--	--	70,477	--	--
. No. Dakota State Employers Assn. Bismarck, No. Dakota	F	IPA	Con	--	--	73,762	--	--
South Dakota								
. Sioux Hlth Maint. Study Grp. Fdn. Sioux Falls, So. Dakota	F	Grp	Phy	--	--	65,608	--	--
Region IX								
Arizona								
. Greenway Med. Trust Phoenix, Ariz.	F	IPA	Phy	--	--	74,952	--	--
. Professional Health Svcs. Tucson, Ariz.	F	Grp	Phy	--	--	73,487	--	--
California								
. Delta Community Hlth Plan Stockton, Calif.	P(s)	IPA	Phy	--	--	75,000	--	--
. Fdn. for Medical Care at Riverside Riverside, Calif.	F	IPA	Phy	--	--	70,000	--	--

TABLE 4: HMO GRANT AND LOAN PROFILES - FISCAL YEAR 1978 (Cont'd)

	TYPE OF GRANT	MODEL	SPONSOR	NON-METRO	MUA	FY 78 GRANT FUNDING	LOANS MADE IN FY 78	DATE OF LOAN
California (Cont'd)								
. Fdn. for Medical Care San Bernadino Calton, Calif.	F	IPA	Phy	--	--	70,000	--	--
. Fdn. Health Plan Sacramento, Calif.	None	IPA	Phy	--	--	--	2,292,000	12/20/77
. HEALS Berkely, Calif.	P(s)	IPA	Hosp	--	--	48,750	--	--
. HMO Concepts Orange, Calif.	None	IPA	Phy	--	--	--	437,000	3/28/78
. Los Padres Group Health San Luis Obispo, Calif.	ID(s) ID	IPA	Con	X	--	129,888 115,620	--	--
. Maxi Care Hawthorne, Calif.	P-X	IPA	Phy	--	--	169,592	--	--
. No. Calif. Inst. for Med. Services Oakland, Calif.	None	IPA	Con	--	--	--	2,500,000	6/1/78
. Pacificare, Inc. Los Angeles, Calif.	ID(s) ID(s)	IPA	Hosp	--	--	84,280 90,000	--	--
. Sierra HMO Reedley, Calif.	ID	IPA	Hosp	X	--	74,371	--	--
. So. L.A. Community Hlth Los Angeles, Calif.	None	Grp	Con	--	--		2,100,000	3/27/78
. Valley Hlth Care, Inc. Sacramento, Calif.	F	Grp	Pri	--	--	75,000	--	--
. Ventura Cty Fdn. Ventura, Calif.	F	IPA	Phy	--	--	70,000	--	--
Hawaii								
. Honolulu Med. Group Research Fdn. Honolulu, Hawaii	F	Grp	Phy	--	--	75,000	--	--

TABLE 4: HMO GRANT AND LOAN PROFILES - FISCAL YEAR 1978 (Cont'd)

	TYPE OF GRANT	MODEL	SPONSOR	NON-METRO	MUA	FY 78 GRANT FUNDING	LOANS MADE IN FY 78	DATE OF LOAN
Region X								
Idaho								
. Idaho HMO	P(s)	IPA	Phy	--	--	26,714	--	--
Boise, Idaho	ID					397,469		
Oregon								
. Capital Hlth Care, Inc.	None	Grp	Con	--	--		[LG] 1,213,000	7/26/78
Salem, Oregon								
. Lane Group Hlth Svcs.	P(s)	IPA	Con	--	--	69,580	--	--
Eugene, Oregon	F					75,000		
	ID					83,200		
Washington								
. Citizens Hlth Care Corp.	F	Grp	Pri	X	--	74,025	--	--
Bellingham, Wash.								
. Kitsap Physician Svcs.	F	IPA	Phy	--	--	64,868	--	--
Bremerton, Wash.								

CHARACTERISTICS OF FEDERALLY QUALIFIED HMOs

CHARACTERISTICS OF FEDERALLY QUALIFIED HMOs

All federally qualified HMOs are required by regulation to submit periodic reports to OHMO on their membership, utilization and finances. Each qualified HMO is classified as Type I, II, or III, according to the strength of its financial condition. The frequency and level of reporting required are based on the HMO's classification. Type III HMOs are those plans that OHMO has determined to be financially sound and, therefore, are required to report only once a year. Type II HMOs are plans currently operating at a planned deficit. A Type II HMO reports to OHMO on a quarterly basis in addition to submitting an annual report. When the actual operating experience of a Type II HMO compares unfavorably with its financial plan, the HMO is reclassified as Type I and is required to submit monthly as well as quarterly reports until its financial condition improves. Type I and II HMOs are usually in the early stages of their operational activity.

The data base for analyzing characteristics of federally qualified HMOs is very limited at this time. Membership, utilization, and financial characteristics described in this section are based upon data submitted by 28 Type II* plans and seven Type III** plans. These HMOs were utilized because the data are complete in all three areas and are available for a minimum of four quarters. Table 5 summarizes the distribution of these plans by type of model. Data for the Type II plans cover the period from July 1977 to June 30, 1978. Data for the Type III HMOs were provided by the last annual report submitted by each plan.

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* The 28 Type II HMOs are as follows:

GROUP MODEL: American Health Plan; Capital Area Community Health Plan; Community Health Care Center Plan, Inc.; GEM Health Association; Genesee Valley Group Health Association; Health Care Plan of New Jersey; Health Services Plan of Pennsylvania; North Communities Health Plan, Inc.; Penn Group Health Plan, Inc.; Prudential Health Care Plan.

STAFF MODEL: Central Essex Health Plan; Connecticut Health Plan; Florida Health Care Plan, Inc.; Georgetown Community Health Plan; Group Health Plan of New Jersey; Metro Health Plan; Prime Health; Piedmont Health Care Corporation; Rhode Island Group Health Association; Rutgers Community Health Plan; Westchester Community Health Plan.

IPA MODEL: Choicecare Health Services; Colorado Health Care Services; Family Health Services; HMO of Illinois; Marion Health Foundation; Portland Metro Health; Rocky Mountian HMO, Inc.

** The Type III HMOs in this analysis include 4 group models: Kaiser Foundation Health Plan of Northern California, Hawaii, Colorado, Ohio, and Oregon; 2 staff models: Family Health Program and Group Health Association; and one IPA model: Maxicare.

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A second analytical approach has been used to look at trends in HMOs. All trend data discussed in this section are based upon those HMOs that have submitted reports covering a minimum of seven consecutive quarters. These plans include only 16 Type II HMOs.***

The membership, utilization, and financial data reported in the following sections are presented to demonstrate what information is currently available on HMOs. Generalizations about the operating characteristics of all HMOs should not be derived from this limited sample of 35 plans. There are numerous variables which have an impact upon the operation of an HMO. These variables include:

- Operational environment: urban vs. rural setting, medical practices in the community
- Organizational model: staff, group, IPA
- Operational age of the HMO
- Membership size
- Enrollment mix: age, sex, income
- Comprehensiveness of benefit package

Because of the inability to quantify many of these variables and the small number of HMOs in each variable category which have comparable characteristics, no firm conclusions about HMOs in general should be drawn.

*** These 16 Type II HMOs include:

GROUP MODEL: Community Health Care Center Plan, Inc.; Genesee Valley Group Health Association; Health Care Plan of New Jersey; Health Services Plan of Pennsylvania; North Communities Health Plan, Inc.; Penn Group Health Plan, Inc.; Prudential Health Care Plan.

STAFF MODEL: Florida Health Care Plan, Inc.; Georgetown Community Health Plan; Piedmont Health Care Corporation; Westchester Community Health Plan.

IPA MODEL: Choicecare Health Services, Inc.; Colorado Health Care Services; Portland Metro Health; Rocky Mountian HMO, Inc.

TABLE 5: DISTRIBUTION OF PLANS BY TYPE OF MODEL

Type of Practice	Type II		Type III	
	Number of Plans	Percent of Plans	Number of Plans	Percent of Plans
All HMOs	28	100	7	100
Group	10	36	4	57
Staff	11	39	2	29
IPA	7	25	1	14

Membership Data

Tables 6-8 present the distribution of membership for the 28 Type II and 7 Type III HMOs. Table 6 shows that 72 percent of the Type II membership is enrolled in group and staff model plans while 99 percent of Type III enrollment is in group and staff models.

Table 6: DISTRIBUTION OF MEMBERSHIP BY TYPE OF MODEL

Type of Practice	Percent of Total Membership	
	Type II	Type III
All HMOs	100	100
Group	40	90*
Staff	32	9
IPA	28	1

* The apparently high enrollment in group model Type III HMOs is attributed to the four Kaiser plans which have been operational for an average of 22 years.

The distribution of membership by size of plan enrollment reported in Table 7 shows that 88 percent of the total enrollment for Type II HMOs occurred in plans with 10,000 or more enrollees. Approximately 99 percent of the total Type III enrollment occurred in 6 plans with over 25,000 enrollees.

TABLE 7: DISTRIBUTION OF HMO MEMBERSHIP BY SIZE OF PLAN

Plan Size	Type II		Type III	
	Number of Plans	Percent of Enrollment	Number of Plans	Percent of Enrollment
All Qualified HMOs	28	100	7	100
Less Than 5,000 Members	6	6	0	0
5,000 - 9,999 Members	3	6	0	0
10,000 - 14,999 Members	11	37	0	0
15,000 - 24,999 Members	5	25	1	1
25,000 or More Members	3	26	6	99

Table 8 summarizes the distribution of membership by age of plan. In general, Type II HMOs are significantly younger than Type III HMOs. Seventy-nine percent of the Type II HMO membership is in plans which have been operational between one and five years. Seven Type III HMOs have been operational for at least five years. Data not reported in the table indicate an average age of 21.9 years for the Type III HMOs.

TABLE 8: DISTRIBUTION OF HMO MEMBERSHIP BY AGE OF PLAN

Time Operational	Type II		Type III	
	Number of Plans	Percent of Plans	Number of Plans	Percent of Plans
All Qualified HMOs	28	100	7	100
1 Year but Less Than 3 Years	13	30	0	0
3 Years but Less Than 5 Years	12	49	0	0
5 or More Years	3	21	7	100

Tables 9 and 10 display the average net increase in enrollment per month. The average net increase in enrollment for Type II HMOs was 543 for the year ending June 30, 1978. The highest rate of increase occurred in individual practice associations. There was a noticeable relationship in the length of time an HMO has been operational and its average net increase in membership per month. Older HMOs tended to have a larger net increase in membership per month. This was confirmed by data for Type III HMOs which have an average increase in enrollment of 1,756 members per month.

TABLE 9: AVERAGE NET INCREASE IN MEMBERSHIP PER MONTH BY TYPE OF PRACTICE

Type of Practice	Type II		Type III	
	Number of Plans	Average* Increase	Number of Plans	Average* Increase
All Qualified HMOs	28	543	7	1,756
Group	10	462	4	2,667
Staff	11	473	2	479
IPA	7	764	1	667

* Weighted by size plan membership.

TABLE 10: AVERAGE NET INCREASE IN MEMBERSHIP PER MONTH BY LENGTH OF TIME OPERATIONAL

Time Operational	Type II		Type III	
	Number of Plans	Average* Increase	Number of Plans	Average* Increase
All Qualified HMOs	28	543	7	1,756
1 Year but Less Than 3 Years	13	535	0	0
3 Years but Less Than 5 Years	12	536	0	0
5 or More Years	3	604	7	1,756

* Weighted by size plan membership.

Utilization Data

Due to a lack of available age/sex specific utilization data, the utilization figures presented in Table 11 have not been age/sex adjusted. The inpatient utilization rate for Type II HMOs for the year ending June 30, 1978 was 444 days per 1,000 members. The staff model HMOs had the lowest utilization rate among these Type II HMOs. Type III HMOs had an inpatient utilization rate of 394 days per 1,000 members.

The ambulatory encounter rate per member per year for Type II HMOs was 4.5 while the rate for Type III HMOs was 4.2 encounters per member per year. As with inpatient utilization, the Type II IPA model HMOs had the highest encounter rate and the staff model HMOs had the lowest rate.

TABLE 11: HOSPITAL UTILIZATION AND AMBULATORY ENCOUNTER RATES BY TYPE OF PRACTICE FOR TYPE II HMOs AND TYPE III HMOs

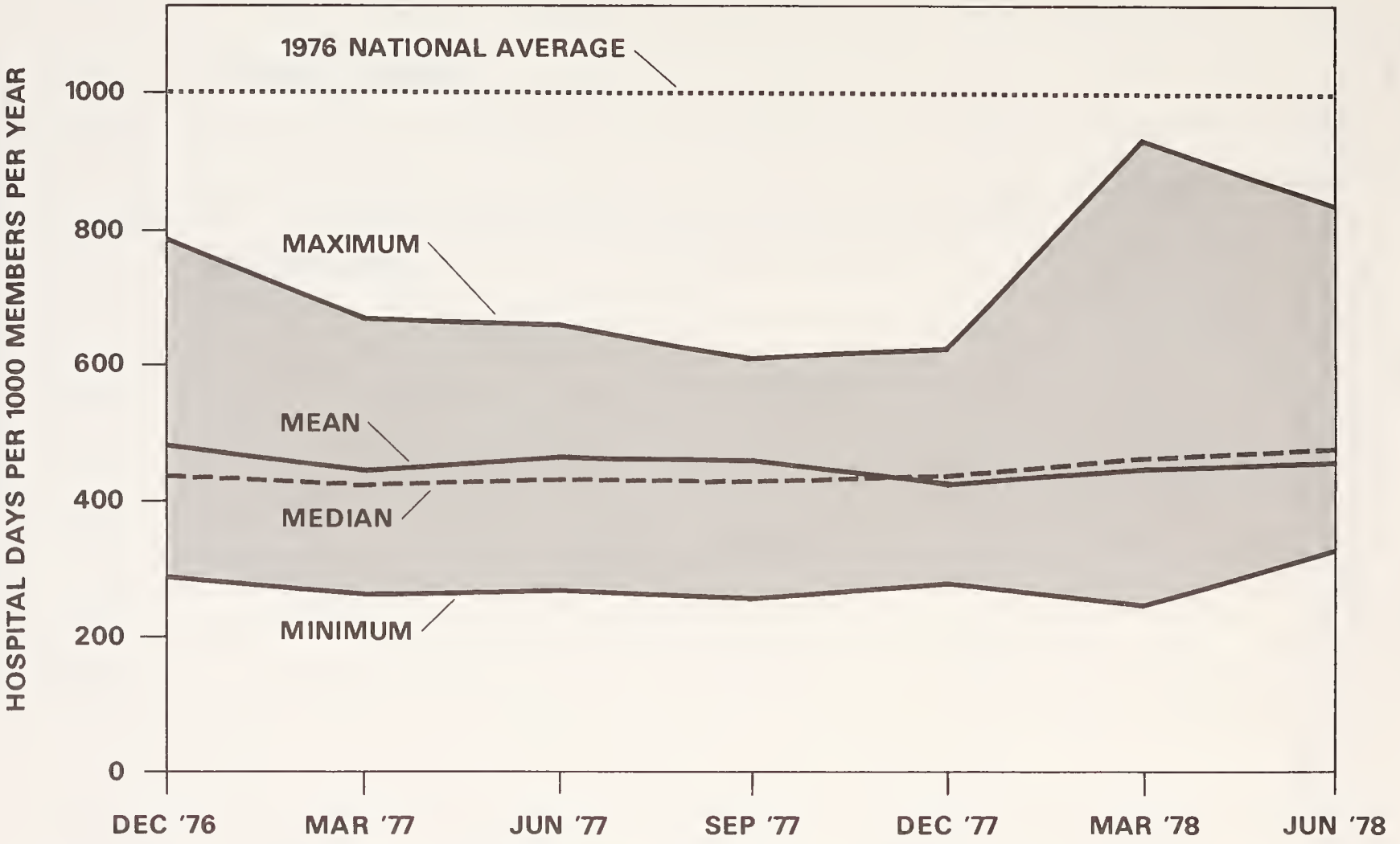
Type of Practice	Number of Plans	Hospital Days Per 1,000 Members Per Year	Ambulatory Encounters Per Member Per Year
Type II HMOs	28	444	4.5
Group	10	449	4.5
Staff	11	405	4.3
IPA	7	481	4.6
Type III HMOs	7	394	4.2

In addition, a trend analysis for ambulatory encounters and hospital utilization was performed. The data base includes the 16 Type II HMOs that have reported for seven consecutive quarters beginning in October 1976. Figure 2 compares hospital utilization for these HMOs with the national average over this time period. The national average is based on the Hospital Discharge Survey from the National Center for Health Statistics. The data have been adjusted to be consistent with the age characteristics of the HMO member population. The result of the adjustment is a utilization rate of 1,022 days per 1,000 members per year. The HMOs have experienced a utilization rate ranging between 400 and 500 days per 1,000. This is a very positive indicator that qualified HMOs are able to keep hospital utilization well below the national average.

Figure 2

HOSPITAL UTILIZATION FOR QUALIFIED HMOs*

By Quarter

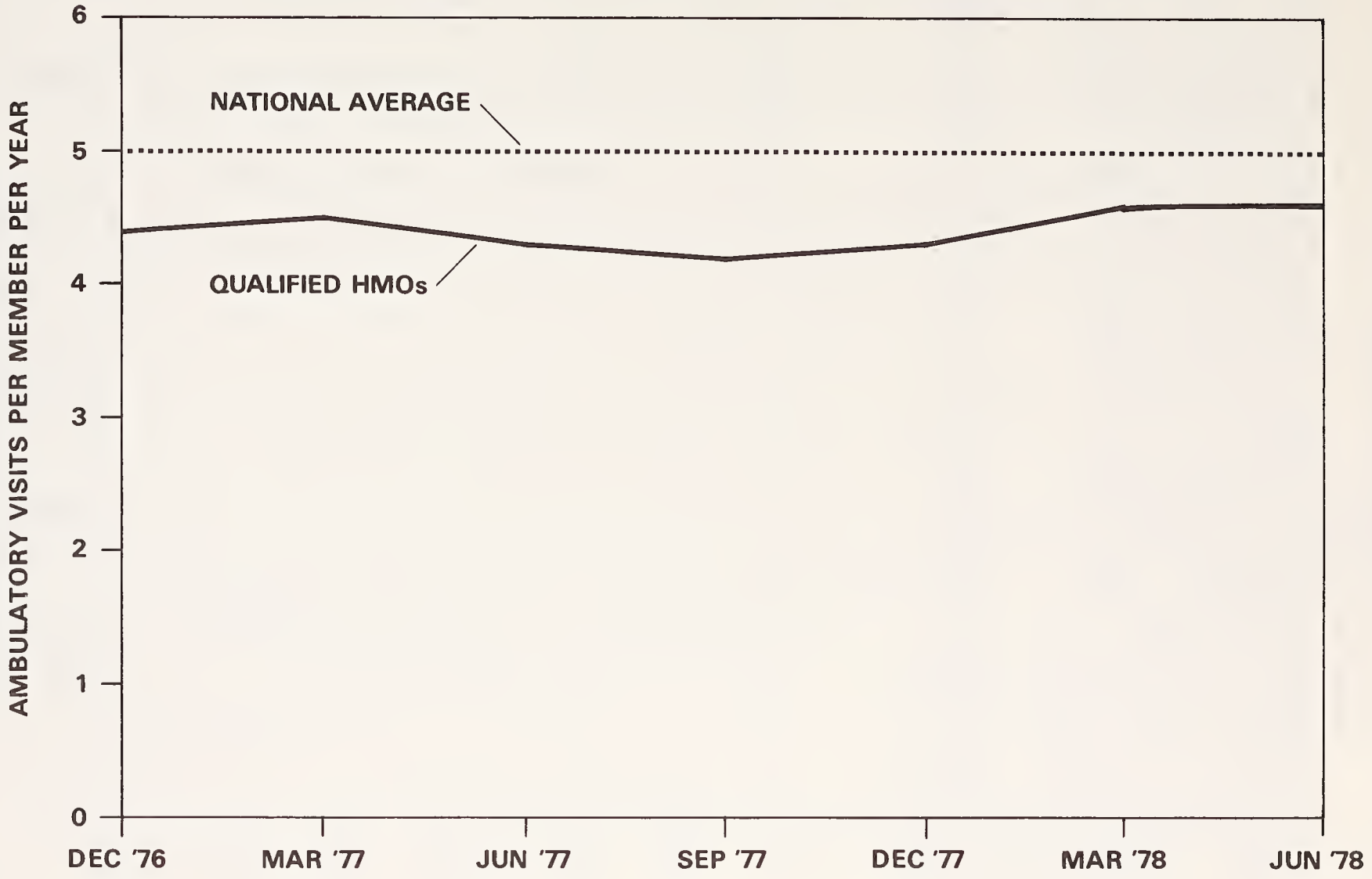


*Based on data from 16 qualified HMOs that reported by June 30, 1978.

Figure 3 presents a trend analysis of ambulatory visits per person per year. Again, the 16 Type II HMOs are compared with the national average. Based upon data from the National Center for Health Statistics, the national average for ambulatory visits has remained constant at about five visits over the entire period. The HMO average varied between 4.2 and 4.6 visits.

Figure 3

AMBULATORY ENCOUNTER RATES IN QUALIFIED HMOs



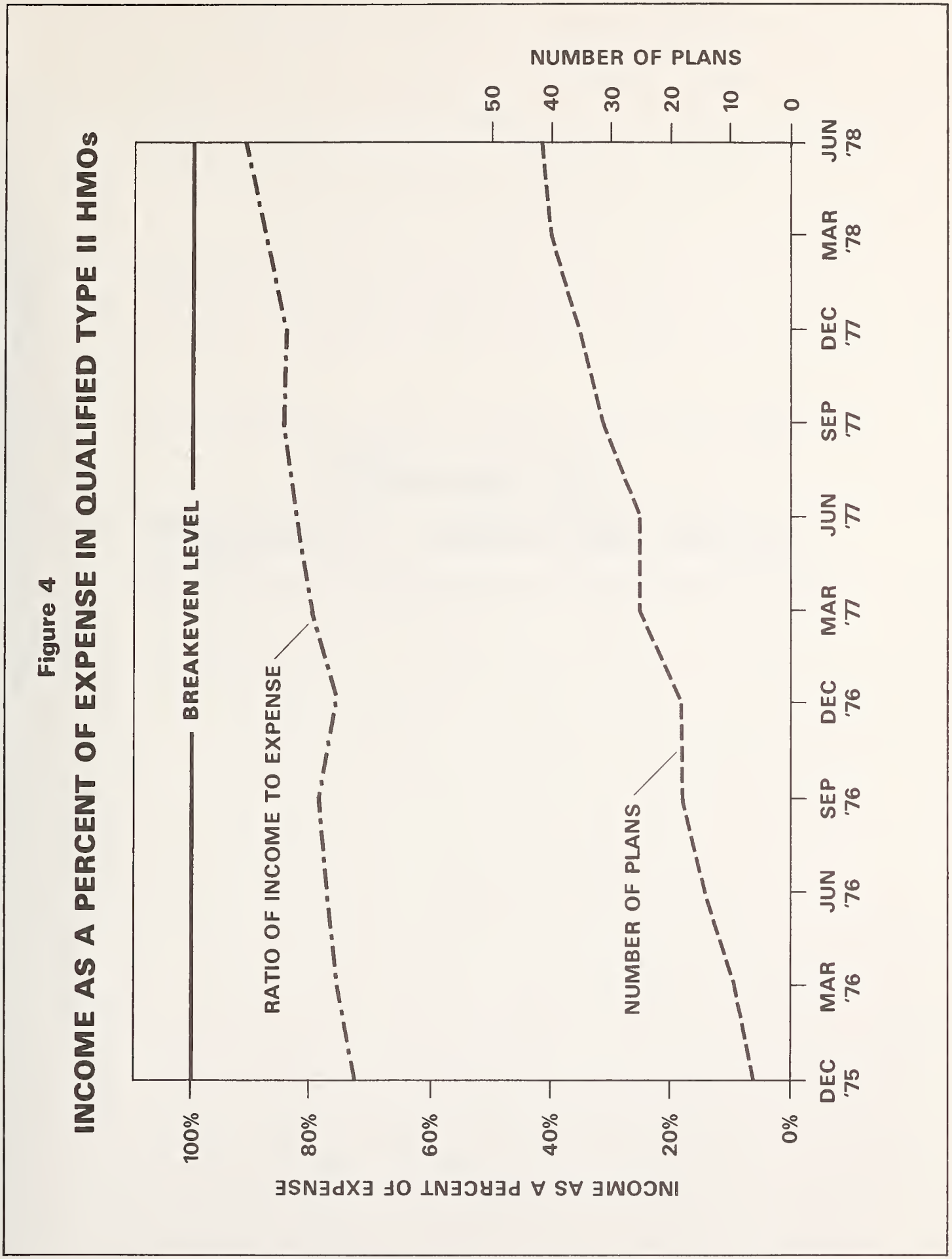
Financial Data

Federally qualified HMOs are, as a group, moving in a positive financial direction. From 1975 when there were 6 plans through the second quarter of 1978 when there were 41 plans in the Type I and Type II categories, the ratio of total income to total expense has increased from 72.5 percent to 90.6 percent. This is a trend indicating that those HMOs are moving toward financial self sufficiency. Figure 4 shows the changes in this ratio over time. It also shows that the number of plans is increasing rapidly without a reduction in this ratio. Thus, despite adding many plans with low enrollment and fixed overhead, the total income of all HMOs has been increasing faster than the total expenses.

For the 7 Type III HMOs as reported in their last annual report, the total income was greater than total expense by 1.5 percent. On a per member per month basis, the income was $27.02 compared to an expense of $26.63.

Figure 4

INCOME AS A PERCENT OF EXPENSE IN QUALIFIED TYPE II HMOs



PROFILES OF FEDERALLY QUALIFIED HMOs

PROFILES OF QUALIFIED HMOs

Sixty-nine HMOs were federally qualified by the close of the fiscal year on September 30, 1978. This chapter shows 73 qualified plans. The difference between the number of qualified HMOs (69) and the number of plans reported here (73) is attributable to the fact that qualified plans such as the Kaiser Foundations Health Plans and the Family Health Programs submitted reports for separate operating components even though qualified as one HMO.

Membership data are shown for 71 of the 73 HMOs. These HMOs range in size from 1,508,887 members to 142 members with a median membership of 14,360 members. Eighty percent of these HMOs have between 2,800 and 99,600 members. These 73 plans have a total of 4,704,465 members. Included in this are 445,475 FEHBP members, 144,668 Medicaid members and 210,308 Medicare members.

Three of the 73 HMOs are in non-metropolitan areas. These three HMOs have a total of 18,139 members. Four of the 73 plans have received Medically Underserved Priority (MUP) funding. These four plans have 52,788 members.

Fifty-one of these 73 plans have received HEW grant assistance totaling 39.1 million dollars.

The inpatient hospital utilization rates in 61 of the 73 plans that show this statistic range from 133 to 836 days per 1,000 members per year. The median rate was 397 days per 1,000 members per year.

The ambulatory encounter rate per member per year in 62 of these plans ranges from 1.3 to 8.3 with a median of 4.2.

ABC-HMO, Inc.
Phoenix, Arizona

Plan Description
Qualification Date: 8/3/78
Sponsorship: Physician/Carrier
Non-Metropolitan: No
Operational Date: 11/72
Type of Practice: Group
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members:*
Total Ambulatory Encounters per Member:*

Membership Data as of 8/30/78
Total: 48,876
Medicaid: 0
Medicare: 10,357
FEHBP: 2,746
Average Net Change per Month:*

Financial Data for Year Ending 6/30/78
Income per Member per Month:*
Expense per Member per Month:*

DHEW Assistance: None

*Plan has not been qualified long enough to submit required reports to DHEW.

Arizona Health Plan
Phoenix, Arizona

Plan Description
Qualification Date: 8/24/78
Sponsorship: Carrier
Non-Metropolitan: No
Operational Date: 10/1/72
Type of Practice: Group
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members:*
Total Ambulatory Encounters per Member:*

Membership Data as of 8/30/78
Total: 43,100
Medicaid: 0
Medicare: 497
FEHBP: 1,211
Average Net Change per Month:*

Financial Data for Year Ending 8/30/78
Income per Member per Month:*
Expense per Member per Month:*

DHEW Assistance: None

*Plan has not been qualified long enough to submit required reports to DHEW.

Maxi-Care
Hawthorne, California

Plan Description
Qualification Date: 3/25/76
Sponsorship: Physician
Non-Metropolitan: No
Operational Date: 3/1/72
Type of Practice: IPA
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 350
Total Ambulatory Encounters per Member: 3.5

Membership Data as of 8/30/78
Total: 22,547
Medicaid: 1,802
Medicare: 115
FEHBP: 48
Average Net Change per Month:*

Financial Data for Year Ending 6/30/78
Income per Member per Month: $39.94
Expense per Member per Month: $36.94

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	$169,592	$169,592
Loans	None	None

*Not Reported

Family Health Program
Long Beach, California

Plan Description
Qualification Date: 7/29/77
Sponsorship: Private
Non-Metropolitan: No
Operational Date: 1965
Type of Practice: Staff
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 351
Total Ambulatory Encounters per Member: 4.2

Membership Data as of 8/30/78
Total: 43,059
Medicaid: 0
Medicare: 3,584
FEHBP: 2,929
Average Net Change per Month:*

Financial Data for Year Ending 6/30/78
Income per Member per Month: $31.67
Expense per Member per Month: $30.51

DHEW Assistance: None

*Not Reported

Note: Family Health Programs in Long Beach, Guam, and Utah have been qualified as one HMO. Utilization and financial data are for all three sites.

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CMG Health Plan
Los Angeles, California

Plan Description
Qualification Date: 7/19/77
Sponsorship: Carrier
Non-Metropolitan: No
Operational Date: 6/66
Type of Practice: Staff
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 347
Total Ambulatory Encounters per Member:*

Membership Data as of 8/30/78
Total: 114,152
Medicaid: 56,861
Medicare: 5,177
FEHBP: 0
Average Net Change per Month:*

Financial Data for Year Ending 6/30/78
Income per Member per Month:*
Expense per Member per Month:*

DHEW Assistance: None

*Not Reported

Kaiser Foundation Health Plan, Inc.
Southern California Region
Los Angeles, California

Plan Description
Qualification Date: 10/27/77
Sponsorship: Community
Non-Metropolitan: No
Operational Date: 1942
Type of Practice: Group
MUA Priority: No

Utilization Data for Year Ending 8/30/78
Hospital Days per 1,000 Members: 405
Total Ambulatory Encounters per Member: 3.3

Membership Data as of 8/30/78
Total: 1,453,414
Medicaid: 9,179
Medicare: 73,685
FEHBP: 121,599
Average Net Change per Month:*

Financial Data for Year Ending 6/30/78
Income per Member per Month:*
Expense per Member per Month:*

DHEW Assistance: None

*Not Reported

Note: Kaiser Foundation Health Plans for the Northern and Southern California Regions and Hawaii have been qualified as one HMO.

South Los Angeles Community Health Plan
Los Angeles, California

Plan Description
Qualification Date: 2/10/78
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 1/73
Type of Practice: IPA
MUA Priority: No

Utilization Data for Year Ending 8/30/78
Hospital Days per 1,000 Members: 247
Total Ambulatory Encounters per Member: 2.7

Membership Data as of 8/30/78
Total: 6,968
Medicaid: 6,127
Medicare: 185
FEHBP: 0
Average Net Change for Month: 178

Financial Data for Year Ending 8/30/78
Income per Member per Month: Not Reported
Expense per Member per Month: Not Reported

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$676,752
Loans	$2,100,000	$2,100,000

Note: Utilization data are for the two-quarter period ending 8/30/78. The plan was not required to report for the previous two quarters. Utilization data have been annualized.

Kaiser Foundation Health Plan, Inc.
Northern California Region
Oakland, California

Plan Description
Qualification Date: 10/27/77
Sponsorship: Community
Non-Metropolitan: No
Operational Date: 1945
Type of Practice: Group
MUA Priority: No

Utilization Data for Year Ending 12/31/77
Hospital Days per 1,000 Members: 372
Total Ambulatory Encounters per Member: 3.6

Membership Data as of 8/30/78
Total: 1,508,887
Medicaid: 0
Medicare: 75,121
FEHBP: 162,068
Average Net Change for Month:*

Financial Data for Year Ending 12/31/77
Income per Member per Month: $26.24
Expense per Member per Month: $26.21

DHEW Assistance: None

*Not Reported

Note: Kaiser Foundation Health Plans for the Northern and Southern California Regions and Hawaii have been qualified as one HMO. This HMO reports annually based on its fiscal year. The utilization and financial information provided here is for their fiscal year ending December 31, 1977.

Family Health Services
Pomona, California

Plan Description
Qualification Date: 12/14/76
Sponsorship: Physician
Non-Metropolitan: No
Operational Date: 5/1/73
Type of Practice: IPA
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 317
Total Ambulatory Encounters per Member: 4.1

Membership Data as of 8/30/78
Total: 19,661
Medicaid: 9,743
Medicare: 51
FEHBP: 45
Average Net Change per Month: 499

Financial Data for Year Ending 6/30/78
Income per Member per Month: $35.65
Expense per Member per Month: $41.63

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	None
Loans	None	$2,500,000

Foundation Health Plan
Sacramento, California

Plan Description
Qualification Date: 12/22/77
Sponsorship: Physician
Non-Metropolitan: No
Operational Date: 1/78
Type of Practice: IPA
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 284
Total Ambulatory Encounters per Member: 2.2

Membership Data as of 8/30/78
Total: 1,227
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change per Month: 167

Financial Data for Year Ending 6/30/78
Income per Member per Month: $50.60
Expense per Member per Month: $177.00

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$710,215
Loans	$2,292,000	$2,292,000

NOTE: Utilization and financial data are for the two-quarter period ending 6/30/78. The plan was not required to report for the previous two quarters. Utilization data have been annualized.

Health Alliance of Northern California
San Jose, California

Plan Description
Qualification Date: 11/29/76
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 4/1/73
Type of Practice: Group
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members:*
Total Ambulatory Encounters per Member:*

Membership Data as of 8/30/78
Total: 23,900
Medicaid: 0
Medicare: 0
FEHBP:0
Average Net Change per Month:*

Financial Data for Year Ending 6/30/78
Income per Member per Month:*
Expense per Member per Month:*

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$722,224
Loans	None	$2,342,000

*Not Reported

Los Padres Group Health
San Luis Obispo, California

Plan Description
Qualification Date: 9/21/78
Sponsorship: Consumer
Non-Metropolitan: Yes
Operational Date: 10/78
Type of Practice: IPA
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members:*
Total Ambulatory Encounters per Member:*

Membership Data as of 8/30/78
Total: 0
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change per Month:*

Financial Data for Year Ending 6/30/78
Income per Member per Month:*
Expense per Member per Month:*

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	$245,508	$723,508
Loans	None	None

*Plan has not been qualified long enough to submit required reports to DHEW.

Comprecare, Inc.
Denver, Colorado

Plan Description
Qualification Date: 8/20/76
Sponsorship: Physician
Non-Metropolitan: No
Operational Date: 7/1/74
Type of Practice: IPA
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 598
Total Ambulatory Encounters per Member: 5.4

Membership Data as of 8/30/78
Total: 33,419
Medicaid: 0
Medicare: 0
FEHBP: 1,630
Average Net Change per Month: 1,949

Financial Data for Year Ending 6/30/78
Income per Member per Month: $28.15
Expense per Member per Month: $25.36

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	$189,723	$718,618
Loans	None	$1,413,000

Kaiser Foundation Health Plan of Colorado, Inc.
Denver, Colorado

Plan Description
Qualification Date: 10/27/77
Sponsorship: Community
Non-Metropolitan: No
Operational Date: 7/69
Type of Practice: Group
MUA Priority: No

Utilization Data for Year Ending 12/31/77
Hospital Days per 1,000 Members: 334
Total Ambulatory Encounters per Member: 2.1

Membership Data as of 8/30/78
Total: 99,565
Medicaid: 0
Medicare: 2,456
FEHBP: 17,920
Average Net Change per Month:*

Financial Data for Year Ending 12/31/77
Income per Member per Month: $24.78
Expense per Member per Month: $23.56

DHEW Assistance: None

*Not Reported

NOTE: This HMO reports annually based on its fiscal year. The utilization and financial information provided here is for the fiscal year ending December 31, 1977.

Choice Care Health Services
Fort Collins, Colorado

Plan Description
Qualification Date: 8/12/76
Sponsorship: Physician
Non-Metropolitan: No
Operational Date: 4/1/74
Type of Practice: IPA
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 320
Total Ambulatory Encounters per Member: 3.6

Membership Data as of 8/30/78
Total: 22,655
Medicaid: 2,792
Medicare: 1,418
FEHBP: 922
Average Net Change per Month: 833

Financial Data for Year Ending 6/30/78
Income per Member per Month: $27.77
Expense per Member per Month: $28.09

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	$68,521	$349,358
Loans	None	$728,000

Rocky Mountain HMO
Grand Junction, Colorado

Plan Description
Qualification Date: 12/29/75
Sponsorship: Physician
Non-Metropolitan: Yes
Operational Date: 1/1/74
Type of Practice: IPA
MUA Priority: Yes

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 725
Total Ambulatory Encounters per Member: 4.7

Membership Data as of 8/30/78
Total: 10,604
Medicaid: 991
Medicare: 1,491
FEHBP: 1,002
Average Net Change per Month: 28

Financial Data for Year Ending 6/30/78
Income per Member per Month: $31.41
Expense per Member per Month: $30.58

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	$14,706	$207,643
Loans	None	$332,000

Connecticut Health Plan
Bridgeport, Connecticut

Plan Description
Qualification Date: 3/15/77
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 3/1/77
Type of Practice: Staff
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 653
Total Ambulatory Encounters per Member: 5.6

Membership Data as of 8/30/78
Total: 5,195
Medicaid: 0
Medicare: 12
FEHBP: 0
Average Net Change per Month: 301

Financial Data for Year Ending 6/30/78
Income per Member per Month: $25.40
Expense per Member per Month: $57.13

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	$75,000	$1,146,042
Loans	None	$2,500,000

Community Health Care Center Plan, Inc.
New Haven, Connecticut

Plan Description
Qualification Date: 10/31/75
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 1/1/71
Type of Practice: Staff
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 540
Total Ambulatory Encounters per Member: 5.3

Membership Data as of 8/30/78
Total: 24,000
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change per Month: 164

Financial Data for Year Ending 6/30/78
Income per Member per Month: $35.26
Expense per Member per Month: $36.61

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$362,461
Loans	None	$2,090,000

Georgetown University Community Health Plan
Washington, D.C.

Plan Description
Qualification Date: 5/26/76
Sponsorship: Medical School
Non-Metropolitan: No
Operational Date: 9/1/73
Type of Practice: Staff
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 415
Total Ambulatory Encounters per Member: 3.7

Membership Data as of 8/30/78
Total: 43,505
Medicaid: 735
Medicare: 0
FEHBP: 0
Average Net Change per Month: 1,148

Financial Data for Year Ending 6/30/78
Income per Member per Month: $28.72
Expense per Member per Month: $28.07

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$884,251
Loans	None	$1,982,000

Group Health Association, Inc.
Washington, D.C.

Plan Description
Qualification Date: 7/18/77
Sponsorship: Community
Non-Metropolitan: No
Operational Date: 1937
Type of Practice: Staff
MUA Priority: No

Utilization Data for Year Ending 8/30/78
Hospital Days per 1,000 Members: 414
Total Ambulatory Encounters per Member: 3.2

Membership Data as of 8/30/78
Total: 109,184
Medicaid: 0
Medicare: 5,281
FEHBP: 70,519
Average Net Change per Month:*

Financial Data for Year Ending 12/31/77
Income per Member per Month: $32.63
Expense per Member per Month: $28.81

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$50,000
Loans	None	None

*Not Reported

NOTE: This HMO reports annually based on its fiscal year. The financial information provided here is for the fiscal year ending December 31, 1977.

Northern California Institute for Medical Services
d/b/a Rockridge Health Care Plan
Oakland, California

Plan Description
Qualification Date: 3/31/78
Sponsorship: Community
Non-Metropolitan: No
Operational Date: 2/74
Type of Practice: IPA
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: Nt Rptd
Total Ambulatory Encounters per Member: Not Reported

Membership Data as of 8/30/78
Total: 7,117
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change for Month: 15

Financial Data for Year Ending 6/30/78
Income per Member per Month: $46.16
Expense per Member per Month: $51.62

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	None
Loans	$2,500,000	$2,500,000

NOTE: Financial data are for the one-quarter period ending 6/30/78. The plan was not required to report for the previous quarters.

HMO Concepts
Orange, California

Plan Description
Qualification Date: 3/17/78
Sponsorship: Physicians
Non-Metropolitan: No
Operational Date: 3/77
Type of Practice: IPA
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 281
Total Ambulatory Encounters per Member: 4.4

Membership Data as of 8/30/78
Total: 14,157
Medicaid: 10,403
Medicare: 7
FEHBP: 0
Average Net Change for Month: 17

Financial Data for Year Ending 6/30/78
Income per Member per Month: Not Reported
Expense per Member per Month:Not Reported

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	None
Loans	$437,000	$437,000

NOTE: Utilization and financial data are for the one quarter period ending 6/30/78. The plan was not required to report for the previous quarters. Utilization data have been annualized.

Prepaid Health Care, Inc.
Clearwater, Florida

Plan Description
Qualification Date: 8/3/78
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 8/78
Type of Practice: Staff
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members:*
Total Ambulatory Encounters per Member:*

Membership Data as of 8/30/78
Total: 142
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change per Month:*

Financial Data for Year Ending 6/30/78
Income per Member per Month:*
Expense per Member per Month:*

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$1,203,886
Loans	$2,500,000	$2,500,000

*Plan has not been qualified long enough to submit required reports to DHEW.

Florida Health Care Plan
Daytona Beach, Florida

Plan Description
Qualification Date: 5/75
Sponsorship: Physician
Non-Metropolitan: No
Operational Date: 8/1/74
Type of Practice: Staff
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 316
Total Ambulatory Encounters per Member: 4.9

Membership Data as of 8/30/78
Total: 9,061
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change per Month: 219

Financial Data for Year Ending 6/30/78
Income per Member per Month: $24.92
Expense per Member per Month: $30.60

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$124,456
Loans	$442,000	$2,500,000

Av-Med Health Plan, Inc.
Miami, Florida

Plan Description
Qualification Date: 9/9/77
Sponsorship: Physician
Non-Metropolitan: No
Operational Date: 10/77
Type of Practice: IPA
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 836
Total Ambulatory Encounters per Member: 2.6

Membership Data as of 8/30/78
Total: 779
Medicaid: 0
Medicare: 28
FEHBP: 0
Average Net Change per Month: 64

Financial Data for Year Ending 6/30/78
Income per Member per Month: $35.18
Expense per Member per Month: $329.55

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	None
Loan Guarantee	$1,100,000	$1,100,000

NOTE: Utilization and financial data are for the three-quarter period ending 6/30/78. The plan was not required to report for the previous quarter. Utilization data have been annualized.

American Health Plan
North Miami Beach, Florida

Plan Description
Qualification Date: 7/29/77
Sponsorship: Physician
Non-Metropolitan: No
Operational Date: 9/73
Type of Practice: Group
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 784
Total Ambulatory Encounters per Member: 4.8

Membership Data as of 8/30/78
Total: 8,462
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change per Month: 147

Financial Data for Year Ending 6/30/78
Income per Member per Month: $26.60
Expense per Member per Month: $31.36

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	None
Loan Guarantee	None	$1,182,000

GEM Health Association
Boise, Idaho

Plan Description
Qualification Date: 6/27/77
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 6/77
Type of Practice: Group
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 262
Total Ambulatory Encounters per Member: 7.1

Membership Data as of 8/30/78
Total: 5,674
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change per Month: 373

Financial Data for Year Ending 6/30/78
Income per Member per Month: $31.34
Expense per Member per Month: $50.90

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$1,124,634
Loans	None	$1,735,000

Anchor Organization for Health
Chicago, Illinois

Plan Description
Qualification Date: 12/20/77
Sponsorship: Hospital
Non-Metropolitan: No
Operational Date: 7/71
Type of Practice: Group
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members:*
Total Ambulatory Encounters per Member: 2.7

Membership Data as of 8/30/78
Total: 20,571
Medicaid: 0
Medicare: 0
FEHBP: 2,005
Average Net Change per Month: 453

Financial Data for Year Ending 6/30/78
Income per Member per Month: $21.01
Expense per Member per Month: $22.22

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	$36,030	$738,728
Loans	None	

*Not Reported

NOTE: Utilization and financial data are for the two-quarter period ending 6/30/78. The plan was not required to report for the previous two quarters. Utilization data have been annualized.

Family Health Program
Tamuning, Guam

Plan Description
Qualification Date: 7/29/77
Sponsorship: Private
Non-Metropolitan: Unknown
Operational Date: 8/1/73
Type of Practice: Staff
MUA Priority: Unknown

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 351
Total Ambulatory Encounters per Member: 4.2

Membership Data as of 8/30/78
Total: 21,000
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change per Month: Not Reported

Financial Data for Year Ending 6/30/78
Income per Member per Month: $31.67
Expense per Member per Month: $30.51

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$32,357
Loans	None	None

NOTE: Family Health Programs in Long Beach, Guam, and Utah have been qualified as one HMO. This plan reports utilization and financial data as one HMO.

Kaiser Foundation Health Plan, Inc.
Honolulu, Hawaii

Plan Description
Qualification Date: 10/27/77
Sponsorship: Community
Non-Metropolitan: No
Operational Date: 1958
Type of Practice: Group
MUA Priority: No

Utilization Data for Year Ending 8/30/78
Hospital Days per 1,000 Members: 433
Total Ambulatory Encounters per Member: 4.2

Membership Data as of 8/30/78
Total: 110,365
Medicaid: 3,082
Medicare: 7,477
FEHBP: 20,385
Average Net Change per Month: Not Reported

Financial Data for Year Ending 12/31/77
Income per Member per Month: $26.50
Expense per Member per Month: $26.37

DHEW Assistance: None

NOTE: Kaiser Foundation Health Plans for the Northern and Southern Regions and Hawaii have been qualified as one HMO. This HMO reports annually based on its fiscal year. The financial information provided here is for their fiscal year ending December 31, 1977.

HMO of Illinois, Inc.
Chicago, Illinois

Plan Description
Qualification Date: 6/15/77
Sponsorship: Unknown
Non-Metropolitan: No
Operational Date: 6/15/77
Type of Practice: IPA
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 348
Total Ambulatory Encounters per Member: 4.2

Membership Data as of 8/30/78
Total: 14,325
Medicaid: 0
Medicare: 73
FEHBP: 0
Average Net Change per Month: 987

Financial Data for Year Ending 6/30/78
Income per Member per Month: $30.45
Expense per Member per Month: $23.07

DHEW Assistance: None

Intergroup Prepaid Health Services, Inc.
Chicago, Illinois

Plan Description
Qualification Date: 4/18/77
Sponsorship: Carrier
Non-Metropolitan: No
Operational Date: 1/1/72
Type of Practice: IPA
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 472
Total Ambulatory Encounters per Member: 1.27

Membership Data as of 8/30/78
Total: 18,000
Medicaid: 0
Medicare: 0
FEHBP: 58
Average Net Change per Month:*

Financial Data for Year Ending 6/30/78
Income per Member per Month: $24.29
Expense per Member per Month: $23.09

DHEW Assistance: None

*Not Reported

NOTE: This HMO reports annually based on its fiscal year. The financial information provided here is for the fiscal year ended December 31, 1977.

Michael Reese Health Plan
Chicago, Illinois

Plan Description
Qualification Date: 4/17/78
Sponsorship: Hospital
Non-Metropolitan: No
Operational Date: 7/72
Type of Practice: Staff
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 710
Total Ambulatory Encounters per Member: 3.4

Membership Data as of 8/30/78
Total: 13,002
Medicaid: 0
Medicare: 59
FEHBP: 4,832
Average Net Change per Month: 6

Financial Data for Year Ending 6/30/78
Income per Member per Month: $39.43
Expense per Member per Month: $38.47

DHEW Assistance: None

NOTE: Utilization and financial data are for the two-quarter period ending 6/30/78. The plan was not required to report for the previous two quarters. Utilization data have been annualized.

North Communities Health Plan, Inc.
Evanston, Illinois

Plan Description
Qualification Date: 5/75
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 5/1/75
Type of Practice: Group
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 505
Total Ambulatory Encounters per Member: 3.2

Membership Data as of 8/30/78
Total: 12,331
Medicaid: 0
Medicare: 0
FEHBP: 375
Average Net Change per Month: 280

Financial Data for Year Ending 6/30/78
Income per Member per Month: $31.47
Expense per Member per Month: $34.19

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	$75,000	$478,618
Loans	$1,250,000	$2,500,000

Metro Health Plan
Indianapolis, Indiana

Plan Description
Qualification Date: 1/31/77
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 11/1/74
Type of Practice: Staff
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 458
Total Ambulatory Encounters per Member: 4.1

Membership Data as of 8/30/78
Total: 15,214
Medicaid: 0
Medicare: 0
FEHBP: 1,149
Average Net Change per Month: 638

Financial Data for Year Ending 6/30/78
Income per Member per Month: $25.56
Expense per Member per Month: $32.59

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	None
Loans	None	$1,264,000

Healthcare of Louisville, Inc.
Louisville, Kentucky

Plan Description
Qualification Date: 4/2/76
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 7/1/74
Type of Practice: Staff
MUA Priority: Yes

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 599
Total Ambulatory Encounters per Member: 3.8

Membership Data as of 8/30/78
Total: 13,209
Medicaid: 0
Medicare: 72
FEHBP: 658
Average Net Change per Month: 351

Financial Data for Year Ending 6/30/78
Income per Member per Month: $25.35
Expense per Member per Month: $33.28

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	$112,091	$1,127,372
Loans	$1,025,000	$2,500,000

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Health Maintenance Organization of Baton Rouge
Baton Rouge, Louisiana

Plan Description
Qualification Date: 3/13/78
Sponsorship: Physician
Non-Metropolitan: No
Operational Date: 4/78
Type of Practice: Group
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members:*
Total Ambulatory Encounters per Member:*

Membership Data as of 8/30/78
Total: 3,553
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change per Month:*

Financial Data for Year Ending 6/30/78
Income per Member per Month:*
Expense per Member per Month:*

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	$88,622	$1,165,175
Loans	$2,500,000	$2,500,000

*Plan has not been qualified long enough to submit required reports to DHEW.

Metropolitan Baltimore Health Care
Baltimore, Maryland

Plan Description
Qualification Date: 4/3/78
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 4/78
Type of Practice: Group
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 218
Total Ambulatory Encounters per Member: 4.9

Membership Data as of 8/30/78
Total: 719
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change per Month: 0

Financial Data for Year Ending 6/30/78
Income per Member per Month: $37.03
Expense per Member per Month: $267.68

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	$237,564	$1,056,875
Loans	$2,500,000	$2,500,000

NOTE: Utilization and financial data are for the one-quarter period ending 6/30/78. The plan was not required to report for the previous three quarters. Utilization data have been annualized.

Harvard Community Health Plan
Allston, Massachusetts

Plan Description
Qualification Date: 9/1/77
Sponsorship: University
Non-Metropolitan: No
Operational Date: 10/69
Type of Practice: Group
MUA Priority: No

Utilization Data for Year Ending 8/30/78
Hospital Days per 1,000 Members: 375
Total Ambulatory Encounters per Member: 2.1

Membership Data as of 8/30/78
Total: 79,071
Medicaid: 920
Medicare: 2,852
FEHBP: 4,287
Average Net Change per Month: Not Reported

Financial Data for Year Ending 6/30/78
Income per Member per Month: $35.19
Expense per Member per Month: $34.66

DHEW Assistance: None

NOTE: This HMO reports annually based on its fiscal year. The financial information provided here is for the fiscal year ending December 31, 1977.

Valley Health Plan
Amherst, Massachusetts

Plan Description
Qualification Date: 5/10/78
Sponsorship: Physician
Non-Metropolitan: No
Operational Date: 10/76
Type of Practice: Group
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members:*
Total Ambulatory Encounters per Member:*

Membership Data as of 8/30/78
Total: 8,275
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change per Month:*

Financial Data for Year Ending 6/30/78
Income per Member per Month:*
Expense per Member per Month:*

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$648,330
Loans	None	None

*Plan has not been qualified long enough to submit required reports to DHEW.

Michigan Health Plans, Inc.
Detroit, Michigan

Plan Description
Qualification Date: 4/13/78
Sponsorship: Physician
Non-Metropolitan: No
Operational Date: 2/74
Type of Practice: IPA
MUA Priority: Yes

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 442
Total Ambulatory Encounters per Member: 5.0

Membership Data as of 8/30/78
Total: 28,975
Medicaid: 26,795
Medicare: 0
FEHBP: 0
Average Net Change per Month: 295

Financial Data for Year Ending 6/30/78
Income per Member per Month: $46.73
Expense per Member per Month: $50.69

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$226,141
Loans	None	None

NOTE: Utilization and financial data are for the one-quarter period ending 6/30/78. The plan was not required to report for the previous quarters. Utilization data have been annualized.

Health Central
Lansing, Michigan

Plan Description
Qualification Date: 12/6/77
Sponsorship: Consumer
Non-Metroplitan: No
Operational Date: 12/77
Type of Practice: Group
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 133
Total Ambulatory Encounters per Member: 2.8

Membership Data as of 8/30/78
Total: 3,881
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change per Month: 724

Financial Data for Year Ending 6/30/78
Income per Member per Month: Not Reported
Expense per Member per Month:Not Reported

DHEW Assistance:	Fiscal Year 1978	Cumulative
TItle XIII Grants	$90,000	$1,171,084
Loans	$2,500,000	$2,500,000

NOTE: Utilization and financial data are for the two-quarter period ending 6/30/78. The plan was not required to report for the previous two quarters. Utilization data have been annualized.

Group Health Plan of Southeast Michigan
Warren, Michigan

Plan Description
Qualification Date: 9/1/77
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 9/20/77
Type of Practice: Staff
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 281
Total Ambulatory Encounters per Member: 3.8

Membership Data as of 8/30/78
Total: 3,600
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change per Month: 347

Financial Data for Year Ending 6/30/78
Income per Member per Month: $30.76
Expense per Member per Month: $98.65

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$1,223,500
Loans	None	$2,500,000

NOTE: Utilization and financial data are for the three-quarter period ending 6/30/78. The plan was not required to report for the previous quarter. Utilization data have been annualized.

SHARE Health Plan
St. Paul, Minnesota

Plan Description
Qualification Date: 6/30/76
Sponsorship: Physician
Non-Metropolitan: No
Operational Date: 1/1/74
Type of Practice: Staff
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 411
Total Ambulatory Encounters per Member: 4.2

Membership Data of 8/30/78
Total: 19,099
Medicaid: 125
Medicare: 0
FEHBP: 366
Average Net Change per Month: 598

Financial Data for Year Ending 6/30/78
Income per Member per Month: $27.17
Expense per Member per Month: $26.30

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	$75,000	$575,000
Loans	None	$850,000

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Matthew Thornton Health Plan, Inc.
Nashua, New Hampshire

Plan Description
Qualification Date: 8/15/78
Sponsorship: Physician
Non-Metropolitan: No
Operational Date: 7/73
Type of Practice: Staff
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members:*
Total Ambulatory Encounters per Member:*

Membership Data as of 8/30/78
Total: 2,828
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change per Month:*

Financial Data for Year Ending 6/30/78
Income per Member per Month:*
Expense per Member per Month:*

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$1,032,621
Loans	$859,000	$859,000

*Plan has not been qualified long enough to submit required reports to DHEW.

Prime Health
Kansas City, Missouri

Plan Description
Qualification Date: 11/26/76
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 11/1/76
Type of Practice: Staff
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members:*
Total Ambulatory Encounters per Member: 4.1

Membership Data as of 8/30/78
Total: 16,204
Medicaid: 0
Medicare: 54
FEHBP: 1,209
Average Net Change per Month: 683

Financial Data for Year Ending 6/30/78
Income per Member per Month: $27.21
Expense per Member per Month: $32.08

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$1,112,381
Loans	None	$2,273,000

*Not Reported

Crossroads Health Plan
East Orange, New Jersey

Plan Description
Qualification Date: 3/17/78
Sponsorship: Physician
Non-Metropolitan: No
Operational Date: 3/78
Type of Practice: IPA
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 253
Total Ambulatory Encounters per Member: 3.5

Membership Data as of 8/20/78
Total: 1,010
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change per Month: 0

Financial Data for Year Ending 6/30/78
Income per Member per Month: $27.05
Expense per Member per Month: $595.87

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	$86,800	$700,921
Loans	$2,500,000	$2,500,000

NOTE: Utilization and financial data are for the one-quarter period ending 6/30/78. The plan was not required to report for the previous quarters. Utilization data have been annualized.

Group Health Plan of New Jersey
Guttenberg, New Jersey

Plan Description
Qualification Date: 6/27/77
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 4/1/77
Type of Practice: Staff
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 314
Total Ambulatory Encounters per Member: 4.4

Membership Data as of 8/30/78
Total: 3,790
Medicaid: 0
Medicare: 0
FEHBP: 141
Average Net Change per Month: 324

Financial Data for Year Ending 6/30/78
Income per Member per Month: $28.90
Expense per Member per Month: $106.40

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	$74,978	$1,244,978
Loans	None	$2,478,000

Health Care Plan of New Jersey
Moorestown, New Jersey

Plan Description
Qualification Date: 5/27/76
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 6/1/76
Type of Practice: IPA
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 407
Total Ambulatory Encounters per Member: 5.6

Membership Data as of 8/30/78
Total: 14,782
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change per Month: 794

Financial Data for Year Ending 6/30/78
Income per Member per Month: $22.11
Expense per Member per Month: $27.35

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	$141,590	$987,759
Loans	None	$1,771,000

Rutgers Community Health Plan
New Brunswick, New Jersey

Plan Description
Qualification Date: 7/1/76
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 7/1/76
Type of Practice: Staff
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 312
Total Ambulatory Encounters per Member: 3.5

Membership Data as of 8/30/78
Total: 24,945
Medicaid: 0
Medicare: 0
FEHBP: 431
Average Net Change per Month: 1,117

Financial Data for Year Ending 6/30/78
Income per Member per Month: $20.40
Expense per Member per Month: $23.77

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$1,125,000
Loans	None	$2,000,000

Central Essex Health Plan
Orange, New Jersey

Plan Description
Qualification Date: 12/28/76
Sponsorship: Hospital
Non-Metropolitan: No
Operational Date: 1/1/77
Type of Practice: Staff
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 265
Total Ambulatory Encounters per Member: 4.8

Membership Data as of 8/30/78
Total: 3,437
Medicaid: 0
Medicare: 0
FEHBP: 286
Average Net Change per Month: 227

Financial Data for Year Ending 6/30/78
Income per Member per Month: $43.42
Expense per Member per Month: $78.11

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$1,044,607
Loans	None	$2,178,000

Capital Area Community Health Plan
Albany, New York

Plan Description
Qualification Date: 12/6/76
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 1/1/77
Type of Practice: Staff
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 444
Total Ambulatory Encounters per Member: 4.2

Membership Data as of 8/30/78
Total: 15,352
Medicaid: 0
Medicare: 36
FEHBP: 1,188
Average Net Change per Month: 600

Financial Data for Year Ending 6/30/78
Income per Member per Month: $26.68
Expense per Member per Month: $29.03

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	$290,469	$1,385,873
Loans	None	$1,832,000

The Health Care Plan, Inc.
Buffalo, New York

Plan Description
Qualification Date: 8/31/78
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 6/1/78
Type of Practice: Group
MUA Priority: Yes

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members:*
Total Ambulatory Encounters per Member:*

Membership Data as of 8/30/78
Total: 0
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change per Month:*

Financial Data for Year Ending 6/30/78
Income per Member per Month:*
Expense per Member per Month:*

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	$9,342	$1,273,807
Loans	$2,500,000	$2,500,000

*Plan has not been qualified long enough to submit required reports to DHEW.

Manhattan Health Plan
New York City, New York

Plan Description
Qualification Date: 10/31/77
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 11/77
Type of Practice: Group
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 234
Total Ambulatory Encounters per Member: 5.8

Membership Data as of 8/30/78
Total: 2,437
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change per Month: 137

Financial Data for Year Ending 6/30/78
Income per Member per Month: $32.84
Expense per Member per Month: $308.99

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$1,174,487
Loans	$2,500,000	$2,500,000

NOTE: Utilization and financial data are for the three quarter period ending 6/30/78. The plan was not required to report for the previous quarter. Utilization data have been annualized.

Genesee Valley Group Health Association
Rochester, New York

Plan Description
Qualification Date: 1/30/76
Sponsorship: Physician
Non-Metropolitan: No
Operational Date: 8/1/73
Type of Practice: Group
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 334
Total Ambulatory Encounters per Member Member: 4.8

Membership Data as of 8/30/78
Total: 35,461
Medicaid: 0
Medicare: 0
FEHBP: 537
Average Net Change per Month: 387

Financial Data for Year Ending 6/30/78
Income per Member per Month: $25.91
Expense per Member per Month: $28.54

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$298,500
Loans	None	$2,500,000

Westchester Community Health Plan
White Plains, New York

Plan Description
Qualification Date: 9/28/76
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 10/1/76
Type of Practice: Staff
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 355
Total Ambulatory Encounters per Member Member: 4.5

Membership Data as of 8/30/78
Total: 12,026
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change per Month: 672

Financial Data for Year Ending 6/30/78
Income per Member per Month: $26.90
Expense per Member per Month: $36.51

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$1,114,902
Loans	None	$2,500,000

Kaiser Community Health Foundation (Ohio)
Cleveland, Ohio

Plan Description
Qualification Date: 10/27/77
Sponsorship: Community
Non-Metropolitan: No
Operational Date: 1/69
Type of Practice: Group
MUA Priority: No

Utilization Data for Year Ending 8/30/78
Hospital Days per 1,000 Members: 499
Total Ambulatory Encounters per Member: 2.8

Membership Data as of 8/30/78
Total: 116,726
Medicaid: 0
Medicare: 5,043
FEHBP: 6,757
Average Net Change for Year: Not Reported

Financial Data for Year Ending 12/31/77
Income per Member per Month: $28.36
Expense per Member per Month: $27.49

DHEW Assistance: None

NOTE: This HMO reports annually based on its fiscal year. The financial information provided here is for the fiscal year ending December 31, 1977.

Marion Health Foundation
Marion, Ohio

Plan Description
Qualification Date: 11/30/76
Sponsorship: Physician
Non-Metropolitan: Yes
Operational Date: 4/1/76
Type of Practice: IPA
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 613
Total Ambulatory Encounters per Member: 6.0

Membership Data as of 8/30/78
Total: 7,535
Medicaid: 0
Medicare: 0
FEHBP: 44
Average Net Change per Month: 439

Financial Data for Year Ending 6/30/78
Income per Member per Month: $26.56
Expense per Member per Month: $26.89

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$419,115
Loans	None	None

Health Maintenance of Oregon
Portland, Oregon

Plan Description
Qualification Date: 6/9/78
Sponsorship:
Non-Metropolitan: No
Operational Date: 7/1/77
Type of Practice: IPA
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 663
Total Ambulatory Encounters per Member: 5.2

Membership Data as of 8/30/78
Total: 1,000
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change per Month: Not Reported

Financial Data for Year Ending 6/30/78
Income per Member per Month: $30.11
Expense per Member per Month: $42.64

DHEW Assistance: None

NOTE: Utilization and financial data are for the one-quarter period ending 6/30/78. The plan was not required to report for the previous quarter. Utilization data have been annualized.

Kaiser Community Health Plan of Oregon
Portland, Oregon

Plan Description
Qualification Date: 10/27/77
Sponsorship: Community
Non-Metropolitan:
Operational Date: 1947
Type of Practice: Group
MUA Priority:

Utilization Data for Year Ending 8/30/78
Hospital Days per 1,000 Members: 396
Total Ambulatory Encounters per Member: 3.1

Membership Data as of 8/30/78
Total: 219,030
Medicaid: 11,043
Medicare: 14,477
FEHBP: 22,988
Average Net Change per Month: Not Reported

Financial Data for Year Ending 12/31/77
Income per Member per Member: $27.34
Expense per Member per Month: $27.18

DHEW Assistance: None

NOTE: This HMO reports annually based on its fiscal year. The financial information provided here is for the fiscal year ending December 31, 1977.

Portland Metro Health, Inc.
Portland, Oregon

Plan Description
Qualification Date: 7/75
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 1/76
Type of Practice: IPA
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 516
Total Ambulatory Encounters per Member: 5.2

Membership Data as of 8/30/78
Total: 15,314
Medicaid: 0
Medicare: 0
FEHBP: 680
Average Net Change per Month: 614

Financial Data for Year Ending 6/30/78
Income per Member per Month: $32.96
Expense per Member per Month: $37.59

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$455,188
Loans	None	$2,500,000

Capitol Health Care
Salem, Oregon

Plan Description
Qualification Date: 3/1/78
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 6/77
Type of Practice: IPA
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 660
Total Ambulatory Encounters per Member: 5.0

Membership Data as of 8/30/78
Total: 6,800
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change per Month: 108

Financial Data for Year Ending 6/30/78
Income per Member per Month: $31.17
Expense per Member per Month: $43.93

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$174,922
Loan Guarantee	$1,213,000	$1,213,000

NOTE: Utilization and financial data are for the two-quarter period ending 6/30/78. The plan was not required to report for the previous two quarters. Utilization data have been annualized.

Health Services Plan of Pennsylvania
Philadelphia, Pennsylvania

Plan Description
Qualification Date: 4/26/76
Sponsorship: Physician
Non-Metropolitan: No
Operational Date: 4/1/74
Type of Practice: Group
MUA Priority: Unknown

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 475
Total Ambulatory Encounters per Member: 4.0

Membership Data as of 8/30/78
Total: 14,353
Medicaid: 0
Medicare: 15
FEHBP: 1,678
Average Net Change per Month: 715

Financial Data for Year Ending 6/30/78
Income per Member per Month: $24.15
Expense per Member per Month: $31.99

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	$227,610	$227,610
Loans	None	$2,213,000

Penn Group Health Plan, Inc.
Pittsburgh, Pennsylvania

Plan Description
Qualification Date: 11/28/75
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 11/1/75
Type of Practice: Group
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 467
Total Ambulatory Encounters per Member: 3.1

Membership Data as of 8/30/78
Total: 17,842
Medicaid: 0
Medicare: 0
FEHBP: 561
Average Net Change per Month: 420

Financial Data for Year Ending 6/30/78
Income per Member per Month: $24.61
Expense per Member per Month: $28.81

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	$896,342	$1,498,781
Loans	$1,050,000	$2,050,000

HMO of Pennsylvania
Willow Grove, Pennsylvania

Plan Description
Qualification Date: 6/17/77
Sponsorship: Unknown
Non-Metropolitan: No
Operational Date: 3/31/77
Type of Practice: IPA
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 465
Total Ambulatory Encounters per Member: 3.8

Membership Data as of 8/30/78
Total: 14,360
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change per Month: 714

Financial Data for Year Ending 6/30/78
Income per Member per Month: $30.52
Expense per Member per Month: $40.05

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$815,106
Loans	None	$2,500,000

Rhode Island Group Health Association
North Providence, Rhode Island

Plan Description
Qualification Date: 10/30/75
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 1/1/70
Type of Practice: Staff
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 393
Total Ambulatory Encounters per Member: 4.5

Membership Data as of 8/30/78
Total: 26,970
Medicaid: 110
Medicare: 695
FEHBP: 1,891
Average Net Change per Month: 413

Financial Data for Year Ending 6/30/78
Income per Member per Month: $30.21
Expense per Member per Month: $31.72

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	$492,255	$1,542,255
Loans	$500,000	$2,500,000

Piedmont Health Care Corporation
Greenville, South Carolina

Plan Description
Qualification Date: 6/75
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 10/30/72
Type of Practice: Staff
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 463
Total Ambulatory Encounters per Member: 4.6

Membership Data as of 8/30/78
Total: 4,764
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change per Month: 126

Financial Data for Year Ending 6/30/78
Income per Member per Month: $28.51
Expense per Member per Month: $28.12

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	$70,860	$70,860
Loans	None	None

Group Health of El Paso
El Paso, Texas

Plan Description
Qualification Date: 2/27/78
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 9/77
Type of Practice: Group
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 834
Total Ambulatory Encounters per Member: 8.3

Membership Data as of 8/30/78
Total: 2,892
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change per Month: 124

Financial Data for Year Ending 6/30/78
Income per Member per Month: $25.21
Expense per Member per Month: $22.41

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	$101,964	$887,491
Loans	$1,145,000	$1,145,000

NOTE: Utilization and financial data are for the two-quarter period ending 6/30/78. The plan was not required to report for the previous two quarters. Utilization data have been annualized.

Prudential Health Care Plan
Houston, Texas

Plan Description
Qualification Date: 6/2/76
Sponsorship: Carrier
Non-Metropolitan: No
Operational Date: 7/1/76
Type of Practice: Group
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 471
Total Ambulatory Encounters per Member: 4.2

Membership Data as of 8/30/78
Total: 15,822
Medicaid: 0
Medicare: 0
FEHBP: 320
Average Net Change per Month: 659

Financial Data for Year Ending 6/30/78
Income per Member per Month: $25.93
Expense per Member per Month: $32.56

DHEW Assistance: None

Family Health Program
Salt Lake City, Utah

Plan Description
Qualification Date: 7/29/77
Sponsorship: Private
Non-Metropolitan: No
Operational Date: 1/1/71
Type of Practice: Staff
MUA Priority: No

Utilization Data for Year Ending 8/30/78
Hospital Days per 1,000 Members: 351
Total Ambulatory Encounters per Member: 4.2

Membership Data as of 8/30/78
Total: 18,000
Medicaid: 3,960
Medicare: 0
FEHBP: 0
Average Net Change per Month: Not Reported

Financial Data for Year Ending 6/30/78
Income per Member per Month: $31.67
Expense per Member per Month: $30.51

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$211,716
Loans	None	None

NOTE: Family Health Programs in Long Beach, Guam, and Utah have been qualified as one HMO and reports utilization and financial data as one HMO.

Cooperative Health Plan of Greater Spokane
Spokane, Washington

Plan Description
Qualification Date: 8/30/77
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 8/1/77
Type of Practice: Group
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 265
Total Ambulatory Encounters per Member: 3.9

Membership Data as of 8/30/78
Total: 10,149
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change per Month: 548

Financial Data for Year Ending 6/30/78
Income per Member per Month: $24.48
Expense per Member per Month: $37.85

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$1,172,480
Loans	None	$2,500,000

NOTE: Utilization and financial data are for the three-quarter period ending 6/30/78. The plan was not required to report for the previous quarter. Utilization data have been annualized.

Sound Health Association
Tacoma, Washington

Plan Description
Qualification Date: 11/74
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 4/1/74
Type of Practice: Staff
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 397
Total Ambulatory Encounters per Member: 4.0

Membership Data as of 8/30/78
Total: 12,019
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change per Month: 281

Financial Data for Year Ending 6/30/78
Income per Member per Month: $28.53
Expense per Member per Month: $34.82

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$304,738
Loans	None	$2,500,000

Group Health Cooperative of South Central Wisconsin
Madison, Wisconsin

Plan Description
Qualification Date: 6/27/77
Sponsorship: Consumer
Non-Metropolitan: No
Operational Date: 3/1/76
Type of Practice: Staff
MUA Priority: No

Utilization Data for Year Ending 6/30/78
Hospital Days per 1,000 Members: 340
Total Ambulatory Encounters per Member: 6.2

Membership Data as of 8/30/78
Total: 4,664
Medicaid: 0
Medicare: 0
FEHBP: 0
Average Net Change per Month: 232

Financial Data for Year Ending 6/30/78
Income per Member per Month: $34.26
Expense per Member per Month: $61.57

DHEW Assistance:	Fiscal Year 1978	Cumulative
Title XIII Grants	None	$1,250,000
Loans	None	$2,500,000

1978 NATIONAL HMO CENSUS OF PREPAID PLANS

294-913 O - 8

1978 NATIONAL HMO CENSUS OF PREPAID PLANS

The Office of Health Maintenance Organizations conducted a census of prepaid health plans during 1978. Information was collected from questionnaires that were mailed out to all prepaid operational plans. For purposes of this census we defined a prepaid health plan as an organization responsible for providing comprehensive health care services, including inpatient and ambulatory care, to an enrolled membership on a prepaid capitated basis. Data for the 1978 Census were reported as of August 30, 1978.

Tabulations of data computed for the 203 prepaid plans appear in Tables 14 - 30. These tables show general characteristics with respect to membership, utilization, and average 1978 family premiums. The data for federally qualified HMOs may differ in these tables from that shown elsewhere in this report because the tables include plans that have been operational for less than a year and because the census data cover a different time period. Highlights of the 1978 census data follow:

- The total number of prepaid health plans in the United States is 203, an increase of 23 percent over 1977.
- The total membership for all plans is 7,470,963, an 18 percent increase over 1977 membership.
- 64 percent of the total membership is in federally qualified plans.
- 86 percent of the total membership is in prepaid group practice plans, and 14 percent in IPAs; and 64 percent of all plans are prepaid group practice plans. The total number of IPAs has increased 75 percent from 1977 to 1978.
- 68 percent of the total membership is in plans that have 100,000 or more members.
- 71 percent of the total membership is in plans that have been operational for ten or more years.
- 37 States and Guam have at least one HMO, 27 States have two or more HMOs, and 6 States have ten or more HMOs.
- 63 percent of the total membership is in the West, with 48 percent of the total membership in California. 32 percent of all the prepaid plans are in the West.
- Inpatient hospital utilization for all plans is 408 days per 1,000 members per year.
- Physician visits per member per year for all plans is 3.4. Total health plan encounters per member per year for all plans is 4.2.
- The average 1978 family premium for all plans is $102.19.

Figure 5

HMOs IN THE UNITED STATES

August 1978

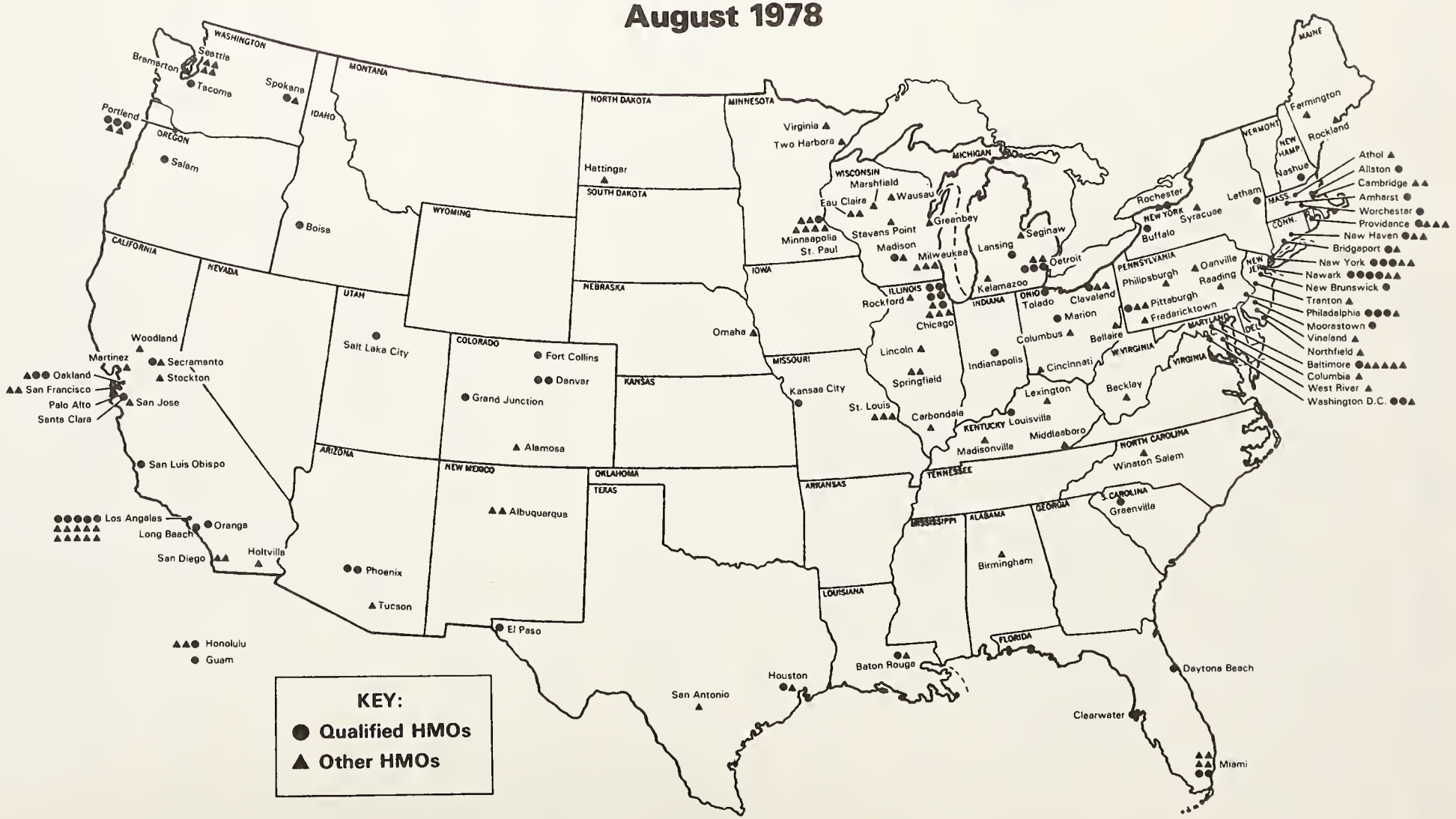

TABLE 12: PREPAID HEALTH CARE PLAN ACTIVITY BY STATE - AUGUST 30, 1978

State	HMO Act or Equivalent	Medicaid Contract	HEW-Supported HMO Projects Active 9/30/78*	Number of Qualified HMOs**	Number of Prepaid Plans	Enrollment***				
						All Prepaid Plans	Qualified HMOs	Medicare	Medicaid	Federal Employees
All Plans	35	21	150	79	203	7,470,963	4,785,442	376,422	229,968	583,445
Alabama			1	0	1	1,219	0	0	0	0
Alaska			1	0	0	0	0	0	0	0
Arizona	X		2	2	3	119,965	91,976	11,013	0	4,576
Arkansas	X			0	0	0	0	0	0	0
California	X	X	13	12	34	3,548,794	3,215,089	161,255	123,960	287,712
Colorado	X	X	6	4	5	173,804	166,243	5,365	3,783	21,474
Connecticut	X		6	2	5	51,804	29,195	284	0	0
Delaware				0	0	0	0	0	0	0
District of Columbia	X	X	3	2	3	167,326	152,689	5,514	812	80,172
Florida	X		6	4	8	122,444	18,444	28	0	0
Georgia			3	0	0	0	0	0	0	0
Hawaii		X	1	1	3	160,508	110,365	9,540	3,082	21,573
Idaho	X		2	1	1	5,674	5,674	0	0	0
Illinois	X	X	5	5	14	155,550	78,229	132	2,295	8,221
Indiana				1	1	15,214	15,214	0	0	1,149
Iowa	X			0	0	0	0	0	0	0
Kansas	X		2	0	0	0	0	0	0	0
Kentucky	X	X	6	1	4	28,764	13,209	970	0	784
Louisiana			3	1	2	15,846	3,553	0	0	0
Maine	X	X		0	2	4,175	0	0	0	0
Maryland	X	X	7	1	8	56,251	719	1,928	7,504	6,992
Massachusetts	X	X	5	3	6	109,288	93,618	2,852	989	4,287
Michigan	X	X	6	4	8	158,605	109,511	5,152	58,361	3,700
Minnesota	X	X	3	1	9	221,650	19,099	1,356	125	12,849
Mississippi			1	0	0	0	0	0	0	0
Missouri			3	1	4	73,358	16,204	9,102	0	1,209
Montana				0	0	0	0	0	0	0
Nebraska	X		2	0	1	7,421	0	0	0	0
Nevada	X			0	0	0	0	0	0	0

Continued on following page.

TABLE 12: PREPAID HEALTH CARE PLAN ACTIVITY BY STATE - AUGUST 30, 1978 (Continued)

State	HMO Act or Equivalent	Medicaid Contract	HEW-Supported HMO Projects Active 9/30/78*	Number of Qualified HMOs	Number of Prepaid Plans	Enrollment**				
						All Prepaid Plans	Qualified HMOs	Medicare	Medicaid	Federal Employees
New Hampshire	X		2	1	1	2,828	2,828	0	0	0
New Jersey	X	X	8	6	10	79,050	47,964	15	3,745	858
New Mexico				0	2	23,309	0	0	0	6,651
New York	X	X	10	6	10	868,998	64,750	79,544	2,267	44,393
North Carolina	X			0	1	18,500	0	0	0	0
North Dakota	X		3	0	1	918	0	0	0	0
Ohio	X	X	6	3	8	172,684	124,261	5,257	716	14,453
Oklahoma	X			0	0	0	0	0	0	0
Oregon		X	3	4	6	274,912	242,144	37,394	11,043	23,668
Pennsylvania	X	X	8	4	11	79,519	48,184	87	1,078	4,350
Rhode Island	X	X	1	1	4	29,419	26,970	695	110	1,891
South Carolina	X	X	1	1	1	4,764	4,764	0	0	0
South Dakota	X		1	0	0	0	0	0	0	0
Tennessee	X		3	0	0	0	0	0	0	0
Texas	X		6	2	4	30,611	18,714	0	0	320
Utah	X	X	1	1	1	18,000	18,000	0	3,960	0
Vermont				0	0	0	0	0	0	0
Virginia			1	0	0	0	0	0	0	0
Washington	X	X	4	2	8	355,739	22,168	37,904	5,556	30,650
West Virginia	X		3	0	1	5,437	0	1,035	0	0
Wisconsin		X	2	1	11	287,915	4,664	0	582	1,513
Wyoming				0	0	0	0	0	0	0
Guam				1	1	21,000	21,000	0	0	0

* Grant supported projects qualified or pursuing qualification.

** Includes HMOs qualified as of November 30, 1978

*** Qualified HMO enrollment as reported for June 1978. Prepaid plan enrollment is as of August 1978.

TABLE 13: NUMBER OF PREPAID HEALTH PLANS AND TOTAL PREPAID ENROLLMENT BY FEDERAL QUALIFICATION STATUS

FEDERAL QUALIFICATION STATUS	NUMBER OF PLANS	1978 MEMBERSHIP
ALL PLANS.....	203	7,470,963
FEDERALLY QUALIFIED.....	79	4,785,442
NOT FEDERALLY QUALIFIED...	124	2,685,521

NOTE: There were 75 federally qualified HMOs as of November 30, 1978. The number 79 federally qualified HMOs appears due to the fact that the Kaiser Foundation Health Plans are counted as 6 HMOs instead of 4 and Family Health Program - Long Beach, Guam, Utah are counted as 3 HMOs instead of 1 in the 1978 census tabulation.

TABLE 14: NUMBER OF PREPAID HEALTH PLANS AND TOTAL PREPAID ENROLLMENT BY TYPE OF PRACTICE - 1978

TYPE OF PRACTICE	NUMBER OF PLANS	1978 MEMBERSHIP
ALL PLANS.....	203	7,470,963
STAFF.....	52	940,097
GROUP.....	78	5,457,178
IPA.....	70	1,050,988
NOT REPORTED.....	3	22,700

TABLE 15: NUMBER OF PREPAID HEALTH PLANS AND TOTAL PREPAID ENROLLMENT BY AGE OF PLAN - 1978

PREPAID PLAN AGE GROUPINGS	NUMBER OF PLANS	1978 MEMBERSHIP
ALL PLANS.....	203	7,470,963
LESS THAN 1 YEAR.....	27	39,438
1 - 2 YEARS.....	42	303,401
3 - 5 YEARS.....	75	871,884
6 - 9 YEARS.....	31	932,234
10 OR MORE YEARS.....	25	5,308,279
NOT REPORTED.....	3	15,727

TABLE 16: NUMBER OF PREPAID HEALTH PLANS AND TOTAL PREPAID ENROLLMENT BY SIZE OF PLAN - 1978

PREPAID PLAN SIZE GROUPINGS	NUMBER OF PLANS	1978 MEMBERSHIP
ALL PLANS.....	203	7,470,963
1 - 4,999.....	68	141,216
5,000 - 14,999.....	59	561,440
15,000 - 24,999.....	37	725,401
25,000 - 49,999.....	16	548,303
50,000 - 99,999.....	5	399,231
100,000 OR MORE.....	12	5,095,372
NOT REPORTED.....	6	0

NOTE: The 6 plans reporting zero membership are plans which became operational in either September or October 1978 and therefore had no membership for the time period covered by the 1978 census.

TABLE 17: NUMBER OF PREPAID HEALTH PLANS AND ANNUALIZED TOTAL ENCOUNTERS PER MEMBER BY FEDERAL QUALIFICATION STATUS - 1978

FEDERAL QUALIFICATION STATUS	NUMBER OF PLANS	ANNUALIZED TOTAL ENCOUNTERS PER MEMBER	MEDIAN ANNUALIZED TOTAL ENCOUNTERS PER MEMBER
ALL PLANS.....	117	4.2	4.1
FEDERALLY QUALIFIED.....	56	4.1	4.3
NOT FEDERALLY QUALIFIED...	61	4.2	4.0

NOTE: This table includes only those plans that reported total encounters in the 1978 census. Total encounters include both physician visits and encounters with other health care professionals, such as physical therapists or nurse practitioners.

TABLE 18: NUMBER OF PREPAID HEALTH PLANS AND ANNUALIZED TOTAL ENCOUNTERS PER MEMBER BY TYPE OF PRACTICE - 1978

TYPE OF PRACTICE	NUMBER OF PLANS	ANNUALIZED TOTAL ENCOUNTERS PER MEMBER	MEDIAN ANNUALIZED TOTAL ENCOUNTERS PER MEMBER
ALL PLANS.....	117	4.2	4.1
STAFF.....	38	4.6	4.3
GROUP.....	41	3.9	4.3
IPA.....	38	4.8	3.4

NOTE: This table includes only those plans that reported total encounters in the 1978 census. Total encounters include both physician visits and encounters with other health care professionals, such as physical therapists or nurse practitioners.

TABLE 19: NUMBER OF PREPAID HEALTH PLANS AND ANNUALIZED TOTAL ENCOUNTERS PER MEMBER BY AGE OF PLAN - 1978

PREPAID PLAN AGE GROUPINGS	NUMBER OF PLANS	ANNUALIZED TOTAL ENCOUNTERS PER MEMBER	MEDIAN ANNUALIZED TOTAL ENCOUNTERS PER MEMBER
ALL PLANS.....	117	4.2	4.1
LESS THAN 1 YEAR.....	12	4.3	3.8
1 - 2 YEARS.....	27	4.3	4.2
3 - 5 YEARS.....	49	4.7	4.4
6 - 9 YEARS.....	16	4.3	3.5
10 OR MORE YEARS.....	12	4.0	4.1
NOT REPORTED.....	1	4.1	4.1

NOTE: This table includes only those plans that reported total encounters in the 1978 census. Total encounters include both physician visits and encounters with other health care professionals, such as physical therapists or nurse practitioners.

TABLE 20: NUMBER OF PREPAID HEALTH PLANS AND ANNUALIZED TOTAL ENCOUNTERS PER MEMBER BY SIZE OF PLAN - 1978

PREPAID PLAN SIZE GROUPINGS	NUMBER OF PLANS	ANNUALIZED TOTAL ENCOUNTERS PER MEMBER	MEDIAN ANNUALIZED TOTAL ENCOUNTERS PER MEMBER
ALL PLANS.....	117	4.2	4.1
1 - 4,999.....	36	4.2	3.9
5,000 - 14,999.....	37	4.2	4.6
14,000 - 24,999.....	23	4.3	4.0
25,000 - 49,999.....	11	5.4	5.3
50,000 - 99,999.....	4	4.2	3.3
100,000 OR MORE.....	6	3.9	4.1

NOTE: This table includes only those plans that reported total encounters in the 1978 census. Total encounters include both physician visits and encounters with other health care professionals, such as physical therapists or nurse practitioners.

TABLE 21: NUMBER OF PREPAID HEALTH PLANS AND ANNUALIZED HOSPITAL DAYS PER 1000 MEMBERS BY FEDERAL QUALIFICATION STATUS - 1978

FEDERAL QUALIFICATION STATUS	NUMBER OF PLANS	ANNUALIZED HOSPITAL DAYS PER 1000 MEMBERS	MEDIAN ANNUALIZED HOSPITAL DAYS PER 1000 MEMBERS
ALL PLANS.....	129	408	438
FEDERALLY QUALIFIED.....	62	397	393
NOT FEDERALLY QUALIFIED...	67	456	472

NOTE: This table includes only those plans that reported hospital utilization in the 1978 census

TABLE 22: NUMBER OF PREPAID HEALTH PLANS AND ANNUALIZED HOSPITAL DAYS PER 1000 MEMBERS BY TYPE OF PRACTICE - 1978

TYPE OF PRACTICE	NUMBER OF PLANS	ANNUALIZED HOSPITAL DAYS PER 1000 MEMBERS	MEDIAN ANNUALIZED HOSPITAL DAYS PER 1000 MEMBERS
ALL PLANS.....	129	408	438
STAFF.....	38	413	396
GROUP.....	49	400	458
IPA.....	42	479	484

NOTE: This table includes only those plans that reported hospital utilization in the 1978 census

TABLE 23: NUMBER OF PREPAID HEALTH PLANS AND ANNUALIZED HOSPITAL DAYS PER 1000 MEMBERS BY AGE OF PLAN - 1978

PREPAID PLAN AGE GROUPINGS	NUMBER OF PLANS	ANNUALIZED HOSPITAL DAYS PER 1000 MEMBERS	MEDIAN ANNUALIZED HOSPITAL DAYS PER 1000 MEMBERS
ALL PLANS.....	129	408	438
LESS THAN 1 YEAR.....	15	315	369
1 - 2 YEARS.....	28	414	398
3 - 5 YEARS.....	50	456	443
6 - 9 YEARS.....	18	422	442
10 OR MORE YEARS.....	16	398	409
NOT REPORTED.....	2	662	453

NOTE: This table includes only those plans that reported hospital utilization in the 1978 census

TABLE 24: NUMBER OF PREPAID HEALTH PLANS AND ANNUALIZED HOSPITAL DAYS PER 1000 MEMBERS BY SIZE OF PLAN - 1978

	NUMBER OF PLANS	ANNUALIZED HOSPITAL DAYS PER 1000 MEMBERS	MEDIAN ANNUALIZED HOSPITAL DAYS PER 1000 MEMBERS
ALL PLANS.....	129	408	438
1 - 4,999.....	42	473	451
5,000 - 14,999.....	38	493	443
15,000 - 24,999.....	24	399	393
25,000 - 49,999.....	12	458	462
50,000 - 99,999.....	4	430	427
100,000 OR MORE.....	9	394	405

NOTE: This table includes only those plans that reported hospital utilization in the 1978 census

TABLE 25: NUMBER OF PREPAID HEALTH PLANS AND 1978 FAMILY PREMIUM BY FEDERAL QUALIFICATION STATUS

FEDERAL QUALIFICATION STATUS	NUMBER OF PLANS	MEAN AVERAGE 1978 FAMILY PREMIUMS	MEDIAN FAMILY PREMIUM
ALL PLANS.....	167	$102.19	$101.35
FEDERALLY QUALIFIED.....	74	100.18	99.54
NOT FEDERALLY QUALIFIED...	93	103.79	103.50

NOTE: This table includes only those plans that reported premium information in the 1978 census. Premium data are based on the most comprehensive high option family premium offered by the plans.

TABLE 26: NUMBER OF PREPAID HEALTH PLANS AND 1978 FAMILY PREMIUM BY TYPE OF PRACTICE

TYPE OF PRACTICE	NUMBER OF PLANS	MEAN AVERAGE 1978 FAMILY PREMIUMS	MEDIAN FAMILY PREMIUM
ALL PLANS.....	167	$102.19	$101.35
STAFF.....	47	96.47	97.23
GROUP.....	62	100.14	97.45
IPA.....	58	109.02	108.73

NOTE: This table includes only those plans that reported premium information in the 1978 census. Premium data are based on the most comprehensive high option family premium offered by the plans.

TABLE 27: NUMBER OF PREPAID HEALTH PLANS AND 1978 FAMILY PREMIUM BY AGE OF PLAN

PREPAID PLAN AGE GROUPINGS	NUMBER OF PLANS	AVERAGE 1978 FAMILY PREMIUMS	MEDIAN FAMILY PREMIUM
ALL PLANS.....	167	$102.19	$101.35
LESS THAN 1 YEAR.....	25	101.97	107.09
1 - 2 YEARS.....	35	95.13	97.15
3 - 5 YEARS.....	64	103.24	103.29
6 - 9 YEARS.....	22	106.96	107.37
10 OR MORE YEARS.....	19	104.21	93.60
NOT REPORTED.....	2	123.41	123.41

NOTE: This table includes only those plans that reported premium information in the 1978 census. Premium data are based on the most comprehensive high option family premium offered by the plans.

TABLE 28: NUMBER OF PREPAID HEALTH PLANS AND 1978 FAMILY PREMIUM BY SIZE OF PLAN

PREPAID PLAN AGE GROUPINGS	NUMBER OF PLANS	AVERAGE 1978 FAMILY PREMIUMS	MEDIAN FAMILY PREMIUM
ALL PLANS.....	167	$102.19	$101.35
1 - 4,999.....	53	99.25	98.98
5,000 - 14,999.....	50	102.79	101.08
15,000 - 24,999.....	30	106.11	104.65
25,000 - 49,999.....	13	101.99	101.41
50,000 - 99,999.....	4	111.01	108.30
100,000 OR MORE.....	11	103.00	93.60
NOT REPORTED.....	6	96.63	91.04

NOTE: This table includes only those plans that reported premium information in the 1978 census. Premium data are based on the most comprehensive high option family premium offered by the plans.

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